FRCH RESEARCH REPORT

Women's Work, Fertility And Access To Health Care

A SOCIO-ECONOMIC STUDY OF TWO VILLAGES IN PUNE DISTRICT

MANISHA GUPTE
ANITA BORKAR

SPONSORED BY

THE TASK FORCE ON HEALTH, NATIONAL COMMISSION

ON SELF-EMPLOYED WOMEN (AND WOMEN IN THE UNORGANISED SECTOR)

OCTOBER 1987

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THE FOUNDATION FOR RESEARCH IN COMMUNITY HEALTH

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The Foundation was established in 1975 as a research institute in the field of health care with special emphasis on the socio-economic and cultural factors which affect the delivery of services. The following are the objectives :

* To collect the cost effectiveness of various models being used in India and other countries.

* To study the cost effectiveness of various models being used in India and other countries.

* To evolve alternative models and methods wherever necessary, which may be more suitable for generalised use in our country-special attention being paid to social, educational, economic and factors which are as important as medical technology in the delivery of health care.

* To undertake field experiments to test the feasibility of the new models and techniques.

* To create awareness and educate people in the problems affecting their health, encourage self help as well as proper utilisation of available public and private medical services.

* To influence governmental policy.

* To create a people's health movement.

AROGYA SHIKSHAN KENDRA

The Arogya Shikshan Kendra in Malshiras village is a field based action research project of the Foundation for Research in Community Health. The study area is located in the drought prone Purandar taluka (tehsil) of Pune district in Maharashtra State and covers a population of 30,000 spread over 18 villages. These villages are also covered by the Primary Health Centre in Malshiras.

This health and development education project, sponsored by the Indian Council of Medical Research (ICMR) does not have service component. Over the next five years, the FRCH team, based in Malshiras would learn people's perceptions about health, identify their health problems and would initiate discussion and debate among the various sections of the population about health and development.

The broad objectives of the project would be :

* To understand the process
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* To identify potential educ

* To initiate a learning pro
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* To work in cooperation wit
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FRCH REPORT

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ANITA BORKAR

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We wish to express our heartfelt gratitude to Dr. N.H. Antia, Director, FRCH, for the approval to conduct this study. We are grateful to him for the constant stimulation from his end, while at the same time allowing for complete freedom in conducting the study. We appreciate the permission that he granted for the use of the FRCH computer as well as of the services of the entire administrative cell of the FRCH.

This study would never have been completed without the cooperation of the staff of the Arogya Shikshan Kendra at Malshiras. We express our sincere gratitude

to Dr. Ramesh Awasthi, the Project Coordinator, not only for his unstinted support but also for constantly participating in the day to day discussions regarding the study. His suggestions have been valuable. Moreover we are grateful to him for constantly baby sitting Prateek Suman (Manisha and Ramesh's son), so that the authors could work undisturbed.

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Sarubai, the TBA in Pondhe not only introduced us to the village women but also fed us with warm meals at short notice. Rajguru Appa provided the same support in Mavdi.

The FRCH collective in Bombay has helped in more than one ways. The intellectual stimulation and the never ending support that the entire group provides creates the most conducive atmosphere for conducting research. We are personally grateful to each member of the collective for the wonderful support that they provided not only during the past five months but for the past so many years. We are grateful to Ravi Duggal for going through the data at various stages and for offering comments. He has also carefully gone through the final manuscript of the quantitative data and has made important suggestions. Manish Mankad has spent innumerable hours with the computer system at FRCH and has enthusiastically simulated all the figures that we have used in the final report. He has also helped in the publication of the report. The stencilling of the final manuscript was done by Ms. Laura Pinto and Eleuterio Fernandes. The cyclostyling has been done by Shashikant and Pramod More. We are grateful to each one of them. Madhu Rokle has done the art work in the report and Aniruddha Choudhury from the Foundation for Medical Research has designed the cover page of the report on the computer. Our sincere gratitude is due to them.

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Since this study is all about bringing visibility to women's work, the acknowledgement cannot be complete without remembering those who stay invisible in this report. Firstly, all our respondents who are really our co-authors. They allowed us unconditionally to peep into their lives on which this report is based. Secondly all the health practitioners who gave us lengthy interviews. Thirdly, the Tambe household, especially Smt.Sumati Tambe and her daughter Nalini who took care of little Prateek at odd times so that the research team of the Arogya Shikshan Kendra could go out into the villages, and fourthly Vijutai and Bai who cooked and cleaned for the field based staff so that they could conduct this visible research study.

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FOREWORD

The Foundation for Research in Community Health is particularly pleased to bring out this report on Women's Work, Fertility and Access to Health Care. This is because health should be primarily concerned with women and their children who comprise almost three quarters of the nations population. The vertically operated MCH programme has unfortunately become an adjunct of the Family Planning effort. It has failed to achieve the desired result as shown by the unacceptably high maternal, infant and child mortality rates and has had little impact on the continued high reproduction rate.

This we believe is chiefly the result of looking on health and population control as a narrow techno-managerial programme which we have tried to impose on the poor without understanding their many more pressing problems and priorities such as for sheer survival. This report clearly demonstrates the importance of human and economic factors without whose understanding no programme can succeed. In any case our poor do not exist merely for the implementation of programmes designed arbitrarily in distant airconditioned offices. Even the best of our Plans have failed because of this yawning gap between those who plan and those for whom the plans are made.

The FRCH was therefore pleased to be represented on the Task Force on Health of the National Commission on

Self Employed Women (and Women in the Unorganised Sector), which then decided to sponsor short term studies on the status of unprotected labouring women. The FRCH undertook to conduct the present study on women at the Employment Guarantee Scheme (EGS) work-sites. The Arogya Shikshan Kendra, a field based action research project of the FRCH provided the study area in the drought prone Purandar taluka of Pune district.

Both authors were based at the Arogya Shikshan Kendra in Malshiras village during the period of this study. Whereas Manisha Gupte is a core group member of the FRCH collective living in Malshiras, Anita Borkar was recruited for a period of four months through the financial support provided by the above Task Force.

This study attempts to bring visibility to the varied aspects of work that rural labouring women perform throughout their lives. Most of the work that these women put in, for example housework, childbearing and childrearing are invisible because they are considered private duties that women perform as an accepted duty. This created the necessary conditions for their exploitation both inside and outside the home. Not only does this generate gross inequality between the two sexes but in practical terms also has an adverse effect on women's health in terms of nutrition, maternity, access and utilisation of health services.

Some interesting findings have emerged. Contrary to the widespread belief that women's wages are only marginally supplementary to the family income, this

study reveals that twenty percent of households are entirely supported by the woman's wages and as many more households are mainly supported by their wages. The study also demonstrates a direct relationship between child death and the number of live births to achieve a final family size with three living children. Also that utilisation of private practitioners' services far exceeds that of the public health services. The fact that people go to private doctors for about seventy percent of illness episodes has been a consistent finding of the various research studies conducted by the FRCH in various regions of Maharashtra.

This investigation has therefore attempted to study women in the non-traditional sector; the data collection also utilises a non-traditional methodology. The structured questionaire, though important is inadequate as a means of collecting information that is intimate and non quantifiable. The authors have therefore relied as much upon personal interviews and group meetings as much as they have upon the structured schedule. The data is presented as a judicious mix of the two findings to make for easier understanding.

Such a short study cannot answer all the questions that concern women's work. What it attempts to do is to point out the lacunae that exist in the knowledge regarding this ill understood and much misunderstood sector and to draw attention to the glaring deficiencies in our knowledge. Many more exploratory and analytical studies will have to be undertaken in depth to understand

this paradigm and to challenge the assumptions on which women's work is conceptualised and defined.

It is hoped that this report will stimulate further interest in this much neglected field and even more important initiate action by dissemination of the findings not only to the policy makers but also the women whose lives are thus affected.

Dr. N.H. Antia
Director,
FRCH.

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P A R T A

OVERVIEW OF THE STUDY

There are few definitions as controversial as that of women's work. Unfortunately, a significant majority, including many women believe that a woman does little or no work. Even when a woman leaves her home to earn wages, her contribution to the family's income is considered marginal. The male is the exalted bread winner and is treated as such; the woman, like her children, is considered dependent. Except in the upper classes where a non-working, bored wife is a prized possession, nothing could be further than the truth as the mythical non-working woman.

In most societies, a woman performs multifold jobs. Only her wage labour, which is the tip of the iceberg is visible. All her other labour, namely domestic labour, reproduction and child rearing, are considered non work. At the most, they may euphemistically be regarded as the labour of love or as the woman satisfying her own biological needs. Even though, in restricted circles there is a strong consciousness of the various social labours that women put in, there is, understandably, resistance within the society at large to accept these views.

For the past one decade, women all over the country have realised with pain and anger, the fact that more lacunae than knowledge exist where many aspects of a woman's life are concerned. The world view of a woman is the male view of a woman, a fact that even women internalise and

which becomes evident in their low self perception. And ironically when women's groups dare to challenge the patriarchial viewpoint of women they are asked to furnish data as proof. The onus to prove that our feelings and our experiences are authentic, lie upon us.

It was with this view in mind that the Task Force on Health, constituted by the 'National Commission on Self Employed Women (also known as the National Commission on Unprotected Labouring Women) decided to commission small, brisk studies on working women's lives. And with a view to conduct such an exploration, the Foundation for Research in Community Health (F.R.C.H.) which was represented on the Task Force, decided to undertake a study on rural, non-agricultural labouring women. The present study was conducted at the Arogya Shikshan Kendra, a field based health education and action project of the F.R.C.H. in the drought prone area of Pune district.

The present study therefore, is an attempt to bring out the various aspects of women's work, how these aspects affect each other and more importantly how they affect the woman's physical and mental well-being. We are not so much concerned with the productivity of a woman in terms of production or reproduction being affected as we are concerned about the woman herself. Our objective therefore has not been to develop models to monitor women's work and output, but to attempt in making her work and output visible.

Since most of women's work lies outside the realm of traditional "work", any traditionally developed tools of identifying her work cannot bring visibility to the

latter. Most often the real story and the history of women's lives surfaces in one to one intimate discussions and where women can speak without being pried upon. We have relied as much upon such expressions as we have upon the responses in our structured interviews. We have held group meetings to provoke the women into enumerating their various kinds of labour and to initiate discussions amongst themselves regarding the same. Details of the methodology are presented in Part C (on Methodology).

We have presented Part B in two sections. Both sections deal with the profile of the project area and the people. Section 1 is an abridged compilation from the Maharashtra State Gazeteers - Pune District, dealing with the generalities of Pune district, its history and its people. Section 2 deals with our own project area and specifically with our respondent households.

We are presenting our data in four chapters in Part D. The first chapter presents a demographic and socio-economic profile of our respondents. It deals with the constellation of the household, their landholding, the agricultural produce, the monetary income, debts, loans and savings, and with housing details.

Chapter 2 in Part D deals with two aspects of women's work, namely wage labour and non paid domestic labour (household chores). It deals with the actual contribution of women's wages to the household's monetary income to test whether this contribution is marginal, supplementary or principal. This chapter also presents occupational and other health hazards that the women reported.

The third chapter in Part D deals with the other two aspects of woman's labour, namely reproduction and child-rearing. This has not been with a view to assess her performance but to understand the magnitute of invisible social labour that she puts in. We have also covered maternal and child health, practices and beliefs related to child birth and menstruation. We have reported upon child mortality and how it increases the load upon women to produce more children. We have also devoted a section to contraception and the related health problems.

The last chapter (Chapter 4 in Part D) deals with illness and access to health care of the respondent and her household. This was with a view to see whether the fact that women worked around the clock affected in any way (whether positively or negatively) their access to health care vis-a-vis the men in their household. We have taken one month as the recall period for enumerating illness episodes.

Chapters 2 and 3 also contain some secondary data. In Chapter 2 we have presented information regarding the Employment Guarantee Scheme (EGS) in Purandar taluka of Pune district (compiled by Dr. Ramesh Awasthi). In Chapter 3 we have compiled and analysed information from the Malshiras Primary Health Centre (PHC) and gram-panchayat (local self-government) records.

Chapters 2, 3 and 4 also contain annexures. Most of these are interesting interviews with health practitioners - Auxillary Nurse Midwives (A.N.M.), Community Health Volunteers (C.H.V.), a private practitioner and a

local 'devrishi' (exorcist and spiritual medium). We have also abridged relevant information from the Maharashtra State Gazeteers - Pune District, which we present as annexures.

The various group meetings with women, at work site or at home, are presented in parts at appropriate places in each chapter along with quantitative data collected through schedules.

Part E attempts to develop a feminist critique on the concept of women's work. We have replaced the conventionally found chapter on recommendations and suggestions by a polemical piece for various reasons. Firstly, this study is only a part of the work of the Task Force on Health. Other contributions, many of them better than ours, deal more comprehensively on recommendations regarding unorganised women. Secondly, in the process of conducting this study we have come to the conclusion that what is required is not just reform or better implementation of existing legislation but a thorough re-questioning of women's roles within and outside home. Whereas we fully endorse all reforms in favour of women, we feel that women must demand what is rightfully theirs.

Therefore even though we have made certain suggestions in Part E like representation of women on all relevant decision-making bodies, we have basically questioned the faulty presumptions that exist in the understanding of women's work.

* * * * * * * * * *

P A R T B

THE AREA AND THE PEOPLE : A PROFILE

Section 1

(Compiled from the Maharashtra State Gazetteers - Pune District)

1. Historical Background

The existence in its vicinity of ancient places of religious importance (e.g., Bhimashankar) and its nearness to well-known trade routes like Nane Ghat and Bor Ghat which have been highways of communication for over 2000 years, make it practically certain that Poona district, as a settled unit of habitation, if of great antiquity. Throughout history the district has been a more or less important region of some bigger State, such as the Andhra, Chalukya, Rashtrakuta or the Yadav empires of the ancient Hindu period, the Bahmani empire, the Nizamshahi sultanate of Bijapur during the medieval Muslim period, Bombay Province under the British regime or of Bombay State since the inauguration of the Sovereign Democratic Republic of India on January 26, 1950.

For a period of approximately one hundred years, ending with the surrender of his territories to the East India Company by Peshwa Baji Rao II, Poona City itself was the seat of the Maratha Empire. Whether the principal seat of local administration was Poona or bearby place in the same region, and whether the local administration was

independent of external authority or not, the region has always occupied an important place in the scheme of the government. The geographical situation and the physical characteristics of the place, as also the peculiar traits of the people inhabiting it seems to have produced this result.

Available historical research goes to show that at least as early as nearly two thousand years ago the region around Poona was a centre of busy and organised life. Agriculture, industry and trade, public charity and religion, government and administration, flourishedin a developed form. Bhimashankar, the most holy place in the district, is also the most ancient, its origin having been lost in legend.

In the sector of administrative organisation relating to institutions of local self-government, Poona from the beginning showed considerable leadership and enthusiasm. Not only was the Poona municipality one of the first municipalities to be set up but it was also the first to have an elected president. The same applies to the District Local Board, Poona, which was the first to have an elected president among the local boards of the Province. More recently, Poona has been the first city in State to have its civic body organised on the model of the Bombay Corporation.

2. Political Uprisings During British Rule

In 1826, a revolt broke out in the southern portion of Poona, in which the Ramoshis were principally involved. Their leader, Umaji Naik, became almost a legendary figure. Though he was captured in 1827, it was soon discovered that the unrest was not so localised in character as the new

Government was led to believe. After the revolt of the Ramoshis, the Kolis in the north-western part of Poona broke into revolt. In 1830, they were temporarily put down, but practically for at least a generation longer, the north-western part of Poona was frequently disturbed by civil disorder. Between the years 1839 and 1846, a rising, which, though not very serious in respect of numbers and the area covered, had a distinctly political intent was staged.

The local population supported the police against the rebels. As many as 54 rebels were tried and two leaders, one of them a Koli, were hanged. Soon afterwards, again in the north-western part of Poona, another band, principally composed of the local Koli population, was formed. They did not as a rule trouble the common people but attacked the patels of villages who to them had become obnoxious as the agents of the new power. A new feature of these risings was the looting of Government treasuries, molestation of patels and employees of the new courts that were set up, and the looting of money-lenders. In Purandar, one Kema Gavli, assisted by sons of Umaji Naik, created a fairly widespread unrest. To aid them in their operations they actually raided the famous temple of Khandoba at Jejuri and took away all the valuables of the place, including the holy image. The image, however, was later on returned. This rising was so serious and widespread that military aid had to be involved to put it down.

3. Food and Diet

The pastoral, artisan and agricultural classes in the district are proverbially fond of chillies and other

hot spices. Besides grain, pulse, fruits, spices, oils, curds and butter, they may eat fish, fowls, eggs and game birds, sheep, goat, hare and wild hog. Few can afford to eat flesh often. They sometimes vow to offer an animal to a god, and after offering its life to the god, eat its flesh often.

They take three meals a day. Their every day fare consists of millet, rice, wheat on occasions, vegetables and fruits, cut in pieces, split pulses and 'alan' or 'jhunaka' (gram flour boiled with cumin, coriander, chillies, salt, turmeric and onions.) They generally breakfast at home on 'bhakri' (bread of unleavened dough) with some vegetable relish or raw onions and about noon, their wives take to the place of work, their dinner of 'bhakri' and vegetables and either, fish, flesh or split pulse. A supper of 'bhakri' or 'bhat' (cooked rice), milk or some liquid preparation of pulse, is eaten at about eight.

4. Houses and Housing

There are first class houses, known as large 'wadas' (mansions) which are generally two storeyed. They are built round quadrangles with stone or fire-baked brick walls, tiled roofs and verandas. In the veranda, strangers are received, children play or the women of the house swing and talk. The ground floor has four to seven rooms, a central hall, a back veranda; and the second storey has four rooms or two halls. At places, such types of houses have two open squares surrounded by rooms and verandas, the first where the men live and the back set apart for women. In the rear of the house are a cattle shed and a

bathing room. A privy is attached to a distant corner either in the front or at the back of the building according to convenience. Buildings like these are owned by inamdars (holders of public grants), jagirdars (big landed proprietors), and wealthy merchants.

Houses of the second class are generally two-storeyed, with walls constructed of dressed or unworked stone and burnt or sun-dried bricks and tiled or flat roofs. A house of this class consists of a front veranda, which is used as an office or place of business, a central room for dining and sitting, room for worshipping gods, a kitchen and a room to spare. There is generally also a cattle shed either in the front or at the back.

Houses of the third class, though smaller than the first two when occupied by a husbandmen, are roomy, and they have large cattle sheds attached. They are one-storeyed and the walls are built of unburnt bricks or mud and stone. They have two rooms and tiled or thatched roofs.

Houses of the fourth and fifth classes are single-roomed thatched huts with walls of mud or mud and wattle reed, millet or cotton stock, and roofed by a bamboo frame and covered by grass or even leaves. Houses of this class are found chiefly in villages and hilly parts of the district and are owned and inhabited by poorer land-holders and field labourers and people of the backward and depressed classes. Except when the number of the cattle is small and a part of the house can be set apart for them, the poorer husbandman's cattle live in sheds or pens separate from the dwelling.

PUNE DISTRICT IN MAHARASHTRA

PUNE, DISTRICT HEADQUARTERS

SASWAD (PURANDAR), TALUKA HEADQUARTERS

PURANDAR TALUKA

P A R T B

section 2

Purandar is one of the fourteen talukas (tehsils) of Pune district. The whole of Purandar taluka lies in the scarcity zone and it is one of the worst hit talukas in the district, receiving an annual rainfall ranging between 600 mm to 700 mm. The tehsil has been facing drought for the past three consecutive years and has not received adequate rainfall ever since the massive drought of 1972.

Pondhe and Mavdi are both small villages with populations of 694 and 811 persons respectively. Both are covered by the Primary Health Centre (PHC) at Malshiras. All the eighteen villages that the PHC covers are situated in Purandar, a drought prone taluka of Pune district. These villages have access through Yewat on the Pune-Sholapur national highway, or from Saswad and Jejuri. The entire area is situated on a plateau at a height of approximately 1000 metres above sea level. Saswad is the taluka headquarters, Jejuri is well-known for the famous temple of Khandoba (drawing tens of thousands of devotees every year from all over Maharashtra), whereas Yewat, though only a large village, has become a busy market place with its own railway station for two reasons. Firstly, the highway passes through Yewat and secondly, the Mula-Mutha canal irrigates most of the land in Yewat. Whereas an acre of land in Malshiras may cost Rs.5,000/- to Rs.10,000/-, the same area of land costs between Rs.1,25,000/- to Rs.1,50,000/-.

Malshiras is also famous locally due to an ancient, beautifully sculptured, 'Hemadpanthi' Shiv temple called Bhuleshwar. Every year on the last Monday of the Hindu month of Shravan (August-September), over 10,000 devotees visit Bhuleshwar. Interestingly, a large share of the village revenue, to date, is pledged to a religious trust, the practice having been initiated during the pre-British Peshwa period. A common trait about all villages here is spacious temples, built with large stones and devoted to various deities, either from the major Hindu pantheon or to local deities which are highly respected and feared.

Weekly Bazaars:

Small grocery shops in the villages sell basic daily requirements such as grains, pulses, oil and soap. In most villages, there is a government recognised food ration shop. However, perishable food items are not usually sold in these villages, unless it is a small stock of local farm fresh vegetables, and this is quite rare. People shop at weekly bazaars. For villagers of Malshiras and Pondhe, the weekly bazaar is at Yewat each Friday and people go down the hill range that day. On all other days, even at Yewat, it is difficult to buy vegetables or potatoes. Villagers of Mavdi shop at Jejuri every Sunday. In Saswad, Monday is the bazaar day.

Bazaar days determine weekly break on EGS work. For example, EGS work in Pondhe would halt on Friday, whereas in Mavdi, on Sunday, people would have their days off at EGS works. No wages are paid for thisweekly holiday.

Accessibility:

Neither Pondhe nor Mavdi have sub-centres of the PHC. Mavdi has better access to medical care, because it is connected to Jejuri, Saswad and Malshiras by public transport. Pondhe though situated closer to Malshiras than is Mavdi (7 kms. as compared to 11 kms.), it is devoid of public transport services. People thus have to hire expensive public transport or trudge on foot, along with the patient. Often they have to carry a woman, in an advanced stage of labour, on a tricky path down the hills to Yewat.

Pondhe is like a remote hamlet on the edge of the plateau. In the British period, Pondhe did not even exist on the map. A sense of timelessness pervades this village and the arrival and departure of our bullock cart would create a small sensation in Pondhe.

Mavdi on the other hand is busier. There is more contact with the world at large, more visitors received and more residents making frequent trips to neighbouring villages and towns. Nights are less dark. The local carpenter and other artisans have flourishing trades.

Drought:

Ever since the massive drought of 1972, there have never been enough rains in this region. For the past four years, the situation has been much worse. For many households, work on EGS sites is the only permanent income. There is even very little grass or shrubery in an area that was once famous all over the state for figs, custard apples and pomegranates.

Women spend as many as three hours each day merely to fill enough water to satisfy household needs. The affluent families in the village buy water every day from the traditional 'koli' (water bearer and fisherfolk) at the rate of Rs.0.75 per two tins of water.

The stark difference between Yewat in Daund taluka and Malshiras in Purandar taluka is visually shocking, with lush grape and sugarcane farms on one side of the Pune - Sholapur highway and desert-like stretches on the other.

In the study area, drought ironically has bridged some of the gap between the small and the large farmers, in terms of agricultural produce. Wells are not a perrenial source of irrigation due to the low water table. However, the tensile strength of the large farmers is seen in the form of the stocks of cattle fodder in their homes and in their ability to procure bank loans.

The People:

The caste composition of this area is typical of most rural societies, with the middle caste (the Marathas) forming the bulk of the population. Though the few Brahmin or Gurav (priests of the middle castes) enjoy a high social status, it is the Marathas (the Waghales in Pondhe, Yadavs in Malshiras and the Devkars and Vaikars in Mavdi), who are politically and economically dominant. Though there is no seething contempt overtly, the Dalit (Scheduled Castes) and Muslim households do not enjoy enviable social status.

An interesting feature of this area is the presence of the "Bara Balutedars" (the twelve occupational castes existing in the subsistence under the traditional Jajmani system). Artisans under this system do not get paid in

monetary terms for their services. The village panchayat pre-decides, depending upon the individual landholding, a fixed quantity of harvest that each household in the village pays to the artisans once a year. As the system exists today, we find that though one member of an occupational caste may have entered the market economy, his brother carried on the 'balutedari'.

Some nomadic tribes such as the Dhangars (cattle herders), the Ramoshi Naiks and the Kaikadis (basket weavers) have settled down in the study areas. In Pondhe, Ramoshi Naiks own a substantial amount of land and the fact that some Marathas are employed on these fields as wage labourers had a positive impact on the status of the Ramoshis. Therefore, though the middle caste birth attendant in Pondhe will not cut the cord herself in a Dalit household, she reluctantly does so where a Ramoshi woman is concerned. The other nomadic tribes bear low social status.

In Mavdi, similar is the case of the Mali (an agricultural caste), who have acquired respectability through landholding even though they be assigned a slightly lower caste status as compared to the Marathas.

Due to the overwhelming presence of famous Hindu shrines, the study area has an unmistakable Hindu ethos. Since the Dalits (many of them converted to Buddhism recently) and the Muslims participate fervently in local festivals, probably there has been a patronising and benevolent attitude towards them from the Hindu caste society.

Another pecularity that was noticed in this area was the tremendous influence that village elders of the socially

respectable communities enjoy. They intervene in quarrels, land disputes and domestic estrangements. They are a force at par. with the panchayat.

Bigamy is notoriously high. Even in the younger generation, it is common for men to take more than one wife. Our general impressions through intense interaction with women of both villages for the past six months point to the fact that bigamy among the Hindus is considerably higher than it is amongst the Muslims.

Housing:

Most houses are constructed by the inhabitants themselves, except in the case of large mansions, which may be constructed by skilled artisans. The bricks are made by moulding and drying a slurry of finely sieved local soil. The roof may be of permanent nature or may be thatched. Houses in the Dalit clusters sometimes even do not have four walls.

Women participate to an equal extent with men in constructing their homes. They participate to an even larger extent in its maintenance. Every week the flooring of all rooms, the courtyard and the backyard are smeared with cowdung by the women. Once in three months the walls are plastered with cowdung and mud.

All the material used in the construction and maintenance of the house, except iron bars and nails, are local. Though by village standards, the cost is not modest, by average city standards the house is certainly low cost.

Ventilation is through gaps between the roof and the walls. There may be smoke outlets in some kitchens but often smoke is merely allowed to drift away, and kitchens tend to be dark and smoky. The "chul" (earthen stove) is built-in, and is repaired and maintained by the woman.

Nutrition and Health:

The daily meals consist of breakfast/early lunch at around nine in the morning. In well-to-do homes it would consist of "bhakri" (made out of unleavened dough of jowar or bajra) and some pulses. In poorer homes, it might be the leftovers of the night, or 'bhakri' and 'chutney' (ground chillies with salt and garlic).

The second meal taken around two in the afternoon is no different from breakfast. In many homes the second meal is supper at twilight, the contents again being the same.

Vegetables are almost invariably absent from the diet of the largest section of the people. Occasionally, there might be a thin curry of dried fish, and rarer still of fresh fish or meat.

We noticed that in rich homes the food is only quantitatively better but not so qualitatively. In all homes the food is extremely spicy and people consume as much as half a kilogram of chilli per week for a family of five. A person's concept of an ideal and balanced diet is reflected in special meals, be they wedding feasts or be they offerings to the gods. In the study area, most weddings irrespective of class have the same menu, namely 'puri' and sweet 'boondi' (made out of gram flour), a dried preparation of whole pulse and a vegetable, usually brinjal and potato and rice with dal.

Pecking order exists in consumption of food, typical to most Indian homes, wherin the adult males eat first, the children eat with the males or immediately after and the women eat last. In very large households, among the women, the daughters-in-law eat even later. In well-to-do houses, this affects the nutrition of women qualitatively, where the choice food like chunks of meat or vegetable may be over before the women sit to eat. In poor households, however, the diet of women is affected even quantitatively, because there might not even be enough bhakri left.

Most health problems are related to poverty and drought. They surface as symptoms of weakness, aches and pains, anaemia and night blindness. It is common for children to have white patches on the face due to worms and malnourishment. In Pondhe, three years ago there was an endemic of hepatitis due to unpotable drinking water.

Unless there are epidemics of influenza or conjunctivitis, most other illnesses are seasonal and again related to lack of adequate food and water. Diarrhoea and dysentery for example, surface at the end of summer, when there is hardly any water left in the wells. Owing to high altitude and dry breezy climate, in spite of appalling poverty, the area is generally conducive to good health. We have seen hardly any case of wet oozing scabies and neither have we heard that persistent coughing at night from the huts, a scene which is so common in many other rural areas. Tuberculosis and leprosy are less frequently found than national averages suggest.

Dogbites and scorpion bites are common; in fact at the PHC in Malshiras, on an average there are a dozen cases of scorpion bites every month. Though snakes are spotted (in the past six months, we have found eleven scorpions and four snakes in our own house in Malshiras), there are no reported fatal cases due to snake bite in the past few years at the PHC.

Schools:

There is a primary school (up to standard sixth) in both Pondhe and Mavdi. There has been a remarkable impact of these schools with most of the relevant age group enrolled. Even otherwise, Pune district ranks first in Maharashtra State where literacy is concerned. In Mavdi, due to high accessibility, there is an incentive for higher education but in Pondhe most girls drop out after completing the sixth standard.

A Tribute To The People:

While we were collecting data, our non-traditional methodology gave us unexpected insight into the personality of the people. As we sat in the kitchen, at the EGS work-site, in the temples, in the fields or at the well, we learnt more than what we had bargained for. The delicate nuances of community life, the unabashed mirth of the women and their vast hospitality in spite of frightening drought, were wholly new to us, as was the fact that many of their children owned no more than one set of clothes each.

For city dwellers it is difficult to imagine as to how the arrival or departure of public transport buses can create ripples of excitement every day. It did not take

very long for us to shed our amusement and to get caught in the same ethos. Soon we were also hotly arguing with the people as to whether the Jejuri S.T. had left on time that day, verifying with our watches the arrivals and departures of buses and were running out of the house to see who came and who left. We remembered respectfully that every day at eight in the morning all respectable citizens gathered at the village bus stop and that it was the best place to meet anybody and everybody important.

Another important community place was the main village temple. Men of all religions often gathered in the afternoons for community siestas. News and gossip were shared here and public opinion moulded. There was no better place for mass communication as the community well where women spent an hour each day to wash clothes. Through this and many experiences we realised first hand as to what was meant by the collective identity of a villager.

Meals were prepared for us at the shortest notice and if we stayed overnight, we were invited to at least four households for tea in the morning. We were presented with peanuts, lemons, raw chillies and flowers, and when we gave a small plastic howl as a gift to the midwife in Pondhe, she delightedly showed it to the whole neighbourhood. In spite of so much tiredness, women agreed to attend our post supper meetings. In their own homes they spoke to us while they cooked, bathed their children, stitched, and they were always cordial.

The profile of these women would not be complete without mentioning their low self perception. Most of them assumed at first that we would not eat out of their pots for caste and class reasons. What touched us most was that in Pondhe in a meeting after midnight, the women asked us most affectionately as to why we were not getting ourselves transferred outside the area. They presumed that we were there on some punishment placement and they urged us to write to our superiors for job transfer. When we told them that we were there out of our free will, the response was mixed. Some sympathised, some laughed and some did not believe us.

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P A R T - C

METHODOLOGY

This is an exploratory study undertaken by the Foundation for Research in Community Health (FRCH) on behalf of the Task Force on Health, National Commission on Self-Employed Women, in two villages in the drought prone area of Purandar taluka of Pune district in Maharashtra State.

The objectives of this short five month study were as follows:

1) To understand various aspects or rural women's work and to bring visibility to the social labour that women put in for society.

2) To study the interrelationship between these various works (namely wage labour, agricultural work, non-paid domestic work, also called housework, childbearing and child rearing) and the effect they have on the woman's physical and mental well-being.

3) To test whether women's contribution to the household's income in monetary terms is marginal, supplementary or principal.

4) To study women's perceptions and beliefs regarding health, pregnancy, childbirth, menstruation and contraception.

5) To study women's access to health care.

Scope of the Study:

Arogya Shikshan Kendra at Malshiras, the field based health education and action project of the Foundation for Research in Community Health covers eighteen villages in Purandar taluka. These eighteen villages are also covered by the Primary Health Centre at Malshiras.

It was decided to derive the sample villages from this area because the existence of a full-fledged project provided the necessary infra-structure and other essential supports to undertake/carry out the research study.

The two villages, Pondhe and Mavdi, were selected as the sample villages. The rationale for selecting these two villages was twofold. Firstly, both had approximately the same population size (694 people and 93 households in Pondhe and 811 people and 133 households in Mavdi), and socio-economic and cultural characteristics. Secondly, even though both the villages were located equidistant from Malshiras, the PHC village, Mavdi was well connected by S.T. buses, whereas Pondhe was devoid of any public transport facilities. This made Mavdi an "accessible" village and Pondhe an "inaccessible" one. Since access to health care formed an important aspect of the study, it was necessary to see whether accessibility of the village itself affected people's access to health facilities.

Sampling:

The list of all the households in Pondhe and Mavdi was obtained from the Talathi's records (updated for 1987). The list contained the names of all heads of households, the caste and landholding of each household.

A twenty percent sample of the total number of households in the village was elicited. Cross stratified on the basis of caste and landholding, a twenty percent of households from each of the categories was elicited through random selection. A household was defined as one kitchen unit. The total sample size for our quantitative data was 20 households in Pondhe and 29 households in Mavdi village.

On the basis of caste, all the households in the two villages were divided into five groups, namely caste Hindus(Marathas,Brahmin, Gurav), the occupational castes (Mali, Nhavi, Sutar), the scheduled castes (Harijan,Neo-Buddhists), the scheduled tribes (Ramoshi, Kaikadi, Dhangars) and the Muslims. Each of these groups was further divided into four strata on the basis of land-holding into large farmers, middle farmers, small farmers and landless households. Twenty percent households from each of these sub-groups were selected through random sampling method, to constitute the sample households of the present study.

However, we realised that the information pertaining to landholding did not tally with the people's version. There was gross difference in the landholding of the seven pilot households, as stated by the respondents and the

recorded data at the Talathi office. As this would lead to serious misrepresentation of the sample, the stratification by landholding was totally deleted and a twenty percent sample, stratified solely on the basis of caste was finally selected as the sample for the study.

Sources of Data and Tools of Data Collection:

Data was collected from primary as well as secondary sources. Though the women, from the two villages, formed the main source of primary data, the health workers also constituted a large source of primary data. Records of the Primary Health Centre, Employment Guarantee Scheme reports and the District Gazetteer formed the secondary source of data.

a) Structured Interview Schedule:

A structured interview schedule was formulated with the intention of collecting data pertaining to the socio-economic background, educational status, occupation and work characteristics, fertility history, morbidity, knowledge and utilisation of the existing health care services by the sample population.

The structured interview schedule proved useful in assimilating data related to variables such as income, fertility and demographic details necessary for a refined quantitative analysis.

The structured interview schedule, as a tool of data collection had its own limitations though. It failed to elicit information related to non-quantifiable variables like health practices and perceptions. Most

of our respondents did not have the concept of preplanned weaning of the child, supplementary nutrition for the growing infant, and hence were not able to answer queries pertaining to it within the rigidity of the structured interview schedule.

For a majority of the women respondents who were never exposed to answering specific structured questions, the interview schedule posed a big threat. These respondents were constantly anxious and repeatedly asked the researchers whether they were answering "correctly" (in the desired manner).

b) Group Meetings:

Informal group meetings with the women proved very useful and enriching as the situation was non-threatening thus enabling the women to converse uninhibited with the researchers. The sample for these meetings was not necessarily that of the quantitative data. In fact, women from different parts and castes of the villages were met separately, at the work sites or in the village.

Though informal, these group meetings were not skewed. The researchers guided and channellised the discussions as per the broad guidelines which were based on various questions and issues reflected in the interview schedule. The main objective of the group meetings was to elicit rich, qualitative aspects to the various questions asked in the interview schedule.

Group meetings with the women were held in both the sample villages as well as at the EGS (work) site. The village meetings were naturally held after supper time.

c) Individual Interviews:

Selected individuals, not necessarily those who constituted our quantitative sample, were interviewed to get a better picture of availability of health services. Community Health Volunteers (CHVs) in both villages, the private practitioner, nurses and a local Devrishi, (exorcist and spiritual medium), were interviewed in depth. The mukadams (supervisors) on EGS work sites were met as also the Agricultural Assistant on EGS. Traditional birth attendants from both villages were interviewed. Some village women were interviewed to get a qualitative picture of the various kinds of work women put in during the whole day. These interviews appear as annexures at the end of Chapters 2 and 3 in Part D (constituting the four chapters on data analysis) or in parts at the appropriate place in the four chapters in Part D.

d) Secondary Data:

To compound the information on knowledge and utilisation of the government health services collected through the structured interview schedule, the following quantitative data was also collected from the records available at the Primary Health Centre.

(1) Birth records of both villages for the past seven years (1980-86 end).
(2) Records of sterilisations and Copper-T insertions of both villages in the Malshiras PHC for the calendar year of 1986.
(3) Details of ANC registration at Malshiras PHC during 1986.
(4) Details of deliveries at Malshiras PHC for both villages during 1986.

Supplementing the information about the EGS works collected through primary sources, a compilation of details about EGS activity in Purandar taluka, by Dr. Ramesh Awasthi is included in the report.

Process of data collection:

The total period of conducting the study was five months. Both the researchers stayed and worked full-time on the study. The residential base of the researchers was Malshiras village, where Arogya Shikshan Kendra is located.

Travel to both the villages included State Transport (ST) services where Mavdi was concerned and bullock cart or bicycle to Pondhe. Occasionally we walked to this inaccessible village.

As would naturally be expected in any rural field study, the time of data collection each day was not nine to five. The best time we found was around sunrise and after sunset. Though this posed practical problems like: visibility at night in non-electrified households especially when we had to write, the respondents were more relaxed after the last meal of the day and the women would also greatly enjoy long group meetings at nights, sometimes these sessions going into the early hours of the morning.

The quantitative schedule was taken either to the home or sometimes to the work site of the respondent. We must mention here that often other individuals such as

the other women of the household stayed present when one woman was being interviewed and at times they also participated in answering. However, we did consider this as violating our data, since we are aware that this situation is typical to most Indian rural societies. On such occasions we did not create water tight compartments between the respondent and her household, but made a note of whatever the 'helper' had to say on a separate pad and treated this as qualitative data.

Concepts:

(1) Landholding Categories:

The categorisation of the sample households on the basis of landholding was done as follows:

No landholding	Landless
Up to 5 acres	Small farmers
5 acres to 20 acres	Middle farmers
20 acres and above	Large farmers

(2) Status/Socio-Economic Strata:

A method of giving scores to each sample household was evolved to categorise the households into high, middle and low socio-economic status.

Scores were given for three main variables — caste, landholding and per capita income of the individual household.

Depending upon the social/political status that each caste had, the following scores were given to the

various castes:

I

Castes	Scores
Brahmin	4
Gurav, Maratha.	3
Mali, Sutar.	2
Dhangar, Ramoshi,Kaikadi	1
Scheduled Castes, Muslims	1

Landholding was the second variable in determining socio economic status. The following scores were given:

II.

Landholding	Scores
More than 20 acres	6
Between 5 acres and 20 acres	4
Up to 5 acres	2
Landless	0

One more point was given to each household which had at least some irrigated oand. There was no graded score for irrigation because the only source of irrigation in both villages were wells, which firstly do not irrigate all of the land and secondly, are not perrenial sources of irrigation.

The third variable used to score for socio-economic status was the per capita income of the household. The income includes the monetary as well as the cash value of annual agricultural produce and has been corrected for total monthly income.

III.

Per capita income	Scores
Rs.500 to Rs.550 p.m.	11
Rs.450 to Rs.500 p.m.	10
Rs.400 to Rs.450 p.m.	9
Rs.350 to Rs.400 p.m.	8
Rs.300 to Rs.350 p.m.	7
Rs.250 to Rs.300 p.m.	6
Rs.200 to Rs.250 p.m.	5
Rs.150 to Rs.200 p.m.	4
Rs.100 to Rs.150 p.m.	3
Below poverty line	
1) Rs.50 to Rs.100 p.m.	2
ii) Up to Rs.50 p.m.	1

The scores for the three variables (Tabloid I, II and III) were added for each individual household to get the total score. The categorisation of the households into high, middle and low socio-economic groups was made as follows:

IV.

Scores	Status
15 and above	High
7 to 14	Middle
Up to 6	Low

Phases of the Study:

June 1987

1. Preparation of the interview schedule.
2. Pilot testing of the interview schedule.
3. Sampling.

July 1987

1. Quantitative data collection.
2. Secondary data collection.
3. Individual interviews.

August 1987

1. Computerisation of quantitative data.
2. Qualitative data collection.
3. Analysis of secondary data.

September 1987

1. Analysis of data.
2. Report writing.

October 1987

1. Report writing.
2. Publication.
3. Submission of Report.

Personnel

1. Two full-time researchers (the authors)
2. One research assistant for one month.
3. Secretarial staff (typists).
4. In more than one way, the FRCH collective, without whose help the work would not have been completed in such a short time.

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P A R T D

PRESENTATION OF DATA

CHAPTER - 1

Demographic and Socio-Economic Profile

Pune district ranks second in population (6.63 percent of the state population) and has the highest literacy rate (54.03 per cent), amongst the 26 districts of the state.

The two sample villages from Purandar taluka, Mavdi and Pondhe, lie equidistant from Malshiras village, which has a Primary Health Centre.

Demographic Profile:

I.

	Population (Actuals)	Households (Actuals)
Pune district	41,64,470*	767,495*
Purandar taluka	1,61,409*	29,298*
Mavdi	811**	133**
Pondhe	693**	93**

* District Census Handbook, Pune 1981.
** Talathi records updated 1987.

II.

	Pondhe (N = 121)	Mavdi (N =191)
1) Average family size		8.69
a) Joint Households	10.85	4.87
b) Nuclear households	3.46	
2) Dependency ratio		0.34
a) by earner	0.31	1.07
b) by age	0.98	
3) Sex ratio (female:male)	806:1000	1011:1000

Note: Figures based on our sample.

As per the District census, 1981, the sex ratio of Mavdi is 1018 and that of Pondhe village is 926, which is far below the sex ratio of Purandar tehsil (1033). The probable reason why our sample population in Pondhe shows an even more unfavourable sex ratio is that our total sample population is too small to make any demographic statements.

Social Structure

As is typical to most societies/villages in rural Maharashtra, the Marathas form the major bulk of the population in both the sample villages, followed by the occupational castes. The caste composition is similar in both the sample villages (Fig.1.1).

For the purposes of this study, the number of married couples in a household was taken as the criterion for determining the structure of the household. Accordingly, a household with one married couple was classified as a nuclear household whilst a household with more than one married couple was classified as a joint household. Both the villages had a higher percentage of nuclear households. (Table 1.1). It is a common feature in the villages, that a large house, termed as "wada" is divided into compartments, each of which forms the residence of one nuclear household. All the households staying in one "wada" are usually related by blood. Such nuclear households, though independent production and consumption units, behave very much like a traditional Hindu joint family for most social and cultural purposes. In fact both our sample villages were more like extended family clusters of the majority caste households, namely the Waghale family in Pondhe and the Devkar and Waikar families in Mavdi. This could be the reason as to why marriages amongst residents of the same village are rare.

The family size of almost all the nuclear households in Mavdi and Pondhe did not exceed beyond six members, whereas majority of the joint households had a higher family size. (Table 1.2). Majority of the joint households had large landholding whilst most of the nuclear households were found to be either landless, or small and middle farmers. (Table 1.3). It was found that where land partition ('Khatefod') had taken place, the family had divided into nuclear households, whereas when land was not distributed within the family, the entire family tended to live as one unit.

Some of the general characteristics of the population are presented in the following tables - Table: 1.4 showing age distribution and Table: 1.5 depicting marital status, of the sample population.

The quantitative data depicts that all the separated, deserted and divorced respondents were women. Not even a single male figured in these categories. All the male respondents were either never married, currently married or widowed. Our qualitative data also corroborates these findings. We noticed that in all separations after marriage, the woman most often remained single whereas the man invariably took another spouse. In fact, sometimes the reason of desertion of one woman could be a bigamous alliance on the man's part, the other reasons being no conception within marriage or simply the whims of the husband. We also realised through our qualitativedata (group meetings) that while the woman perceived herself to be "deserted", the man even if separated, did not feel the stigma of "desertion", since more often than not, he was the deserter. Women who were deserted invariably

stayed with their natal family. In the group meetings, we also saw that some deserted women lived with their in-law's family, without the husband. Only one woman from our quantitative sample, a widow, lived on her own. She had no son and her three daughters were married. For the women invariably, the first marriage is the only marriage. The men remarried but we did not find any man who had remarried a widow or a divorcee. Men generally married much younger and unmarried women, whether it was their own first marriage or not.

Land:

Agriculture being the chief source of livelihood in both the villages, at least in the absence of persisting drought, landholding is one of the important indicators of the socio-economic status of the population. Landholding pattern in both the villages indicates a very low percentage of landless households. Further, it also depicts a polarisation in landholding pattern, with the large farmers, who constitute only one fourth of the total sample population in both the villages, owning the largest share of cultivable land. (56% and 70% of the land was owned by large farmers in Pondhe and Mavdi respectively). (Source: our sample, Table 1.6). When landholding was correlated with caste it was found that in Pondhe as well as in Mavdi no high caste household was landless. As opposed to this in both villages, no low caste household rose above the small farmer category. (Table 1.7)

Conversely, of the five large farmers in Pondhe, four were from the upper caste and one household was from the middle castes. In Mavdi, all the seven households who were large farmers, were upper caste. In both villages, all middle farmers (four households in Pondhe and eleven households

in Mavdi) were upper caste.

Among the small farmers, in Pondhe out of ten households, six were high caste, one was middle caste and three were low caste households. The only landless household from our sample in Pondhe, belonged to the lower caste. In Mavdi, of the nine small farmer households, four were upper caste, two were middle caste and three were low caste. Of the two landless households from our sample in Mavdi, one was middle caste and the other was low caste.

Even our small quantitative sample shows that the majority of the land in both villages is owned by the upper caste.

	Total area (in hectares)	Percentage of cultivable land	Percentage of irrigated land
Purandar tehsil	1,06,734	76.69	10.61
Mavdi	1,005	91.88	7.22
Pondhe	1,102	62.97	4.46

Source: District Census Handbook, Pune, 198.

Irrigation:

In a drought prone area, a small piece of irrigated land is economically more viable than a large expanse of unirrigated land. In Purandar tehsil, only 10.61 percent of the cultivable land is irrigated. Wells are the major source of irrigation in the taluka and were found to be the only

source of irrigation in the two villages. Many wells however go dry in the summer months and therefore are not a perrenial source of irrigation.

Though the percentage of irrigated landholding in Mavdi is nearly five times that of Pondhe (Table: 1.8), the percentage of irrigated landholding is directly proportional to the landholding pattern in both the villages, with large farmers owning most of the irrigated land. (Table: 1.9).

Agricultural Produce:

Jowar and Bajra are the two main crops grown in the region and they constitute the staple food of the population.

Aggregate Annual Agricultural Produce of our sample households

	Pondhe (20 households)	Mavdi (29 households)
Jowar	6510 Kgs.	8865 Kgs.
Bajra	5960 Kgs.	3115 Kgs.
Wheat	-	700 Kgs.
Onion	500 Kgs.	3000 Kgs.

Bajra is sown at the onset of the monsoon and is harvested five months later, whereas jowar, which requires comparatively less amount of water than bajra, is sown after bajra has been harvested.

Both bajra and jowar are mono-grop cultivations. People grow jowar in preference to bajra because it yields a better income. In the retail shop, jowar is priced between Rs.2.00 to Rs.2.50 per kg., whereas bajra is sold at Rs.2.00 per kg. Even in the absence of a significant difference in these prices, the jowar plant is an excellent fodder for cattle and therefore serves as an additional income to the farmer, either through direct sale or by feeding one own's cattle. Wheat, onion, chilli are grown only on irrigated lands.

Monthly Household Income:

Both in Mavdi and Pondhe, half of the sample households had monthly (household) income of less than Rs.500/- (below the Integrated Rural Development Programme (IRDP) poverty line). Household income has been calculated as the aggregate of the total monetary income, cash value of agricultural produce and income derived from other sources (rent, or money received from migrated wage earning family members).

For the remaining half of the households in both the villages, the monthly household income ranged from Rs.500/- to Rs.2,000/-. Only one household from Mavdi reported to have an income of more than Rs.2,000/- p.m. (Table: 1.10).

Per capita income

35% of our total sample from both villages were below the poverty line (Rs.100/- per capita per month), though within the two villages there was a slight variation. Whereas in Pondhe, 47% of the households were BPL, in Mavdi 62% were BPL. The proportion of households drawing between

Rs.100/- to Rs.200/- per individual monthly were similar in both villages (37% in Pondhe and 31% in Mavdi). The details are presented in Fig. 1.2.

Within the BPL category, the data is even more startling. 44% of the BPL category in Pondhe earns less than Rs.50/- per capita per month whereas in Mavdi, 50% earn less than Rs.50/- per capita. 44% of the households in the BPL category in Pondhe earn less than Rs.75/- per capita per month and 28% in Mavdi earn the same.

Educational Status

The majority of the sample population below 14 years of age (83% in Pondhe and 91% in Mavdi) were presently attending school, whereas only 45% of adults in Pondhe and 54% in Mavdi have attended at least one year of formal schooling in their childhood. (All our data on education excludes the under five population). This data reveals that a presence of at least a primary school in both the villages has had a positive impact on the school attendance of the population, since a large part of the relevant age group (5-14 years) is currently in school. Our data does not reveal any sex bias in the school attendance of this population. (Tables: 1.11 and 1.12).

Our qualitative data depicts that school drop-out (especially for girl students) is simultaneous with reaching the highest standard (grade) of schooling available in one's own village. For example, in Pondhe most girls leave school after completing standard sixth because the school in Pondhe does not have the seventh standard.

In a meeting with school girls in Pondhe, we found that only three girls from the village attend the high school in Malshiras and that they have to walk seven kms., one way, every day. One girl said that she was in the 8th std. In that case she would be the only one to have reached this grade currently in Pondhe. However, when her mother arrived, the latter said that from this academic year (beginning June) onwards, the girl's education had been stopped. When asked as to to why, she said "I can't send a young (pubertal) girl unescorted in the hilly tract to Malshiras every day, can I?"

There is some difference in the level of schooling, past and present, between the two villages, though both have schools up to the sixth standard. Mavdi being accessible, understandably has a higher population of those who have had a chance to attend school, since children can take public transport to neighbouring villages that have a high school.

In Pondhe 20% of our sample households were entirely illiterate. In 35% of the sample households, the highest level of education was primary schooling and in 25% households it was middle level (5th to 7th Std.) of schooling. 15% households reported the highest achievement of education to be high school and only one household (5%) reported junior college (Std. 12th) to be the highest level of education in their household.

In Mavdi, 3% households did not have even a single member who had ever attended school. In 10% of the household the highest level of education was primary schooling while 35% of the households had middle level of schooling

as the hightest level of education in the household. 41% of the total households reported to have secondary level as the highest level of schooling. One household (3%) claimed Std.12th as the highest level of education while two households reported a diploma to be the highest level of education in their households. (Figure 1.3).

The average highest level of education was Std.4th in Pondhe and Std. 7th in Mavdi. Though 80% of the households in Pondhe, and 97% of the households in Mavdi have reported at least one year of formal schoolingas the highest level of education in their households (some even reporting high school and diploma), we are aware that the highest level of schooling is not representative of the educational status of the entire household. In fact, in most households the reported highest education would be the achievement of one single individual. The rest of the household would be much less formally educated, probably even never having attended school.

We have therefore even taken into consideration the lowest level of formal schooling in each household. We suspect that in most households that report a favourable highest level of education it is the present generation that has achieved this status, and this fact is partially evident by the fact that a large majority of our adult population is not highly educated.

Educational status of the head of the household, to a large extent, reflects the social status of the household. It also has a bearing on other factors such as, for example, awareness about existing resources or better utilization of available services. Data regarding the

educational status of the head of the household was uniform in both the sample villages, with almost half of the heads of households having never attended school. The single head of the household who had completed his matriculation was from Mavdi village. (Tables 1.13).

It is interesting to note that in the majority of the households, (90% in Pondhe and 86% in Mavdi), there was at least one woman per household who had never attended school. In a small percentage of households (50% in Pondhe and 38% in Mavdi) at least one male member per household had never attended school.

House Ownership:

Ownership of the place of residence is a common feature of most rural life-styles. A majority of the households (80% and 97% in Pondhe and Mavdi respectively) owned their place of residence. The remaining households in both the villages, stayed in houses belonging to their close relatives who had given the house as a goodwill gesture until the respondents were able to secure or build a residence of their own.

Most of the houses in both the villages were built of stone, and had roof-tiles and mud floors. In the few houses which had a tiled flooring, it was only the living room that had such tiles; all the other rooms had mud floors which required a weekly plastering with cowdung. The houses of the Harijans of Pondhe, the Dhangars and Kaikadis were mostly "kuccha" houses with thatched roofs and mud walls.

Electricity:

65.09% of the villages in Pune district avail of electricity. (Source: District Census Handbook, 1981, Pune). Although electricity has reached almost all the villages in Purandar tehsil, majority of the households (95% in Pondhe as compared to 62% in Mavdi) did not have an electric connection in their own home, as they were not able to afford it (an electric connection/metre costs Rs.300/- in the village.)

In Mavdi, the status-wise (status was derived from Socio-Economic stratum of household) distribution of electricity was in the ascending order, quite normally as one expects it to be. In Pondhe, the only household having electricity was a middle (dominant) caste joint household with large landholding and with about the largest annual agricultural produce in the whole village (Table:1.14).

Other household facilities:

Apart from electricity, no household in either of the two villages reported to have other household facilities like gobar gas, sanitation or a latrine. In Mavdi, though a community gobar gas plant was installed by the Government in the 'Harijan ali' (cluster of scheduled castes homes) it was never put to use because of lack of water and cowdung. The community had neither demanded nor contributed financially towards this plant. It was the government's decision to install this gobar gas plant in dalit clusters through one of the rural uplift programmes.

Loans and Savings:

In Pondhe only 25% of the households reported to have taken loans as compared to 69% of the households from Mavdi.

In both the villages, a majority of the households had taken loans for consumption purposes which included wedding expenses, repayment of smaller debts or just day to day survival. (Table: 1.15). Only three households from Mavdi had taken loans for production purposes (installing a lift/electric motor for the well), out of which the amount of loan taken by two households was around Rs.25,000/- each.

In Pondhe, the only household who had taken loan for consumption did not have a savings account which means that the household did not have enough money to save, which further explains the purpose of taking loans.

In Mavdi, only 18% of the households which had taken loans for consumption did not have a savings account whereas all the three households which had taken loans for production purposes had savings accounts. It can be clearly inferred as far as these three households are concerned that having a savings account reflects upon the credibility and the repayment capacity of the debtors and it is possible that the advancement of large loans for production purposes is facilitated by the fact that these households have bank accounts.

Table: 1.15 shows the correlation of the amounts of loans with the purpose for which they were taken. In Pondhe, all households which took loans had done so for consumption. These five households together took loans amounting to Rs.21,900/- making for an average of Rs.4,380/- per household.

In Maydi, of the twenty households, from our sample, which took loans, seventeen had taken loans for consumption while three households had taken loans for production

purposes. It is interesting that all seventeen households took loans amounting to Rs.68,800/- (averaging to Rs.4,047/- per household), whereas the three households took loans worth Rs.52,500/- for production, the average per household in this case being Rs.17,500/-.

This data shows that not only are two kinds of loans taken, but two kinds of people take loans for two specific purposes, namely consumption and production. All the three households which took loans for production were highly assetted. They came from the upper socio-economic stratum, being large farmers with irrigated land.

This distribution shows that whereas for one section, which forms the majority, loans are taken when the household income is not enough to meet the basic needs. Loans therefore further deplete the assets of the household. For the other section forming a small minority, loans enhance assets accumulation because increased input in agricultural production yields more produce.

Year after year, this cycle increases disparity between the assetted and the assetless, whereby the capacity of the rich in terms of savings, investment and taking larger loans is enhanced. Thereby they draw a richer dividend. The poor on the other hand having consumed the entire loan amount, would have no choice but to either mortgage their few assets or get into further indebtedness.

FIG.1.1(a) CASTE COMPOSITION

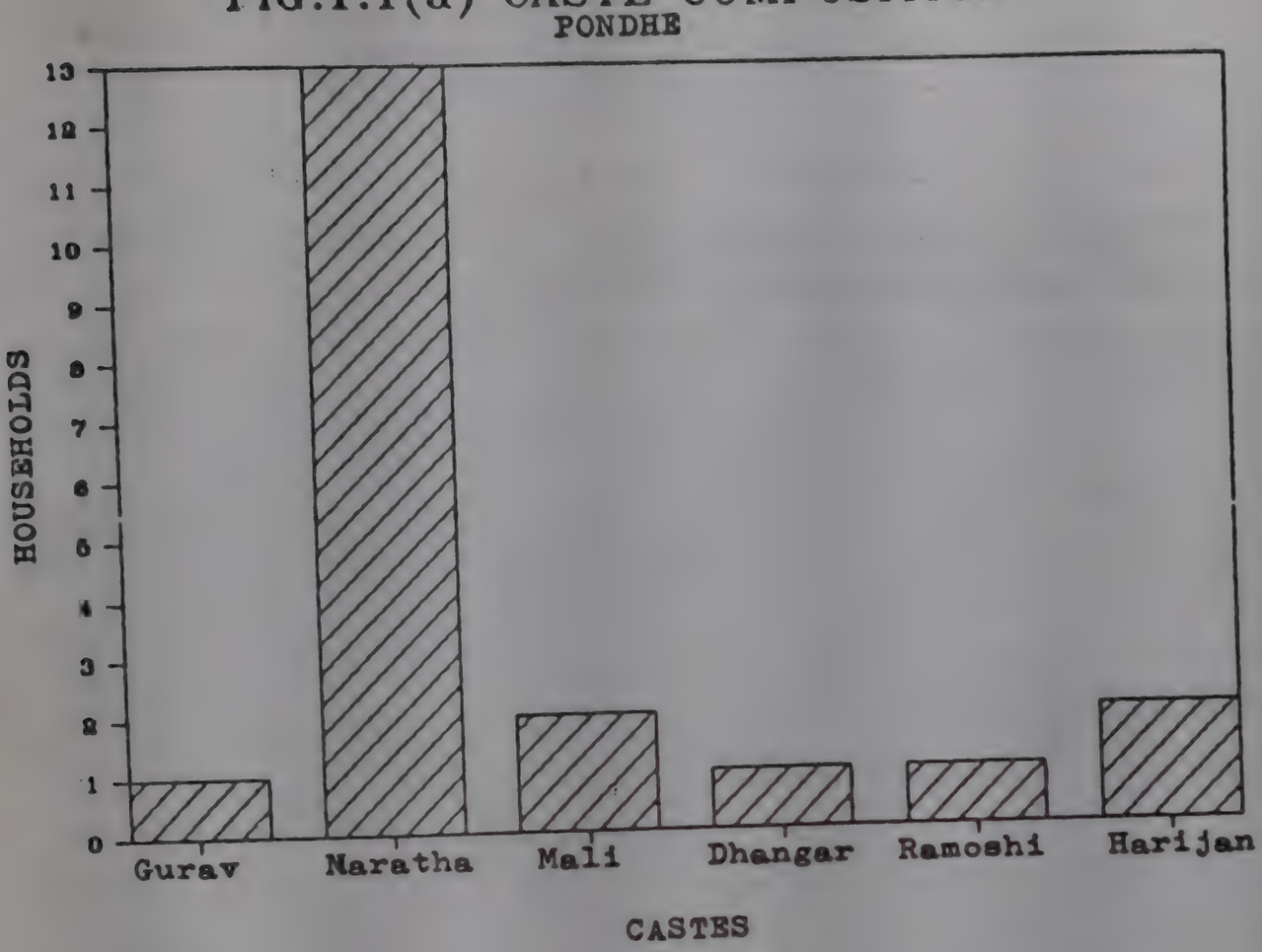


FIG.1.1(b) CASTE COMPOSITION

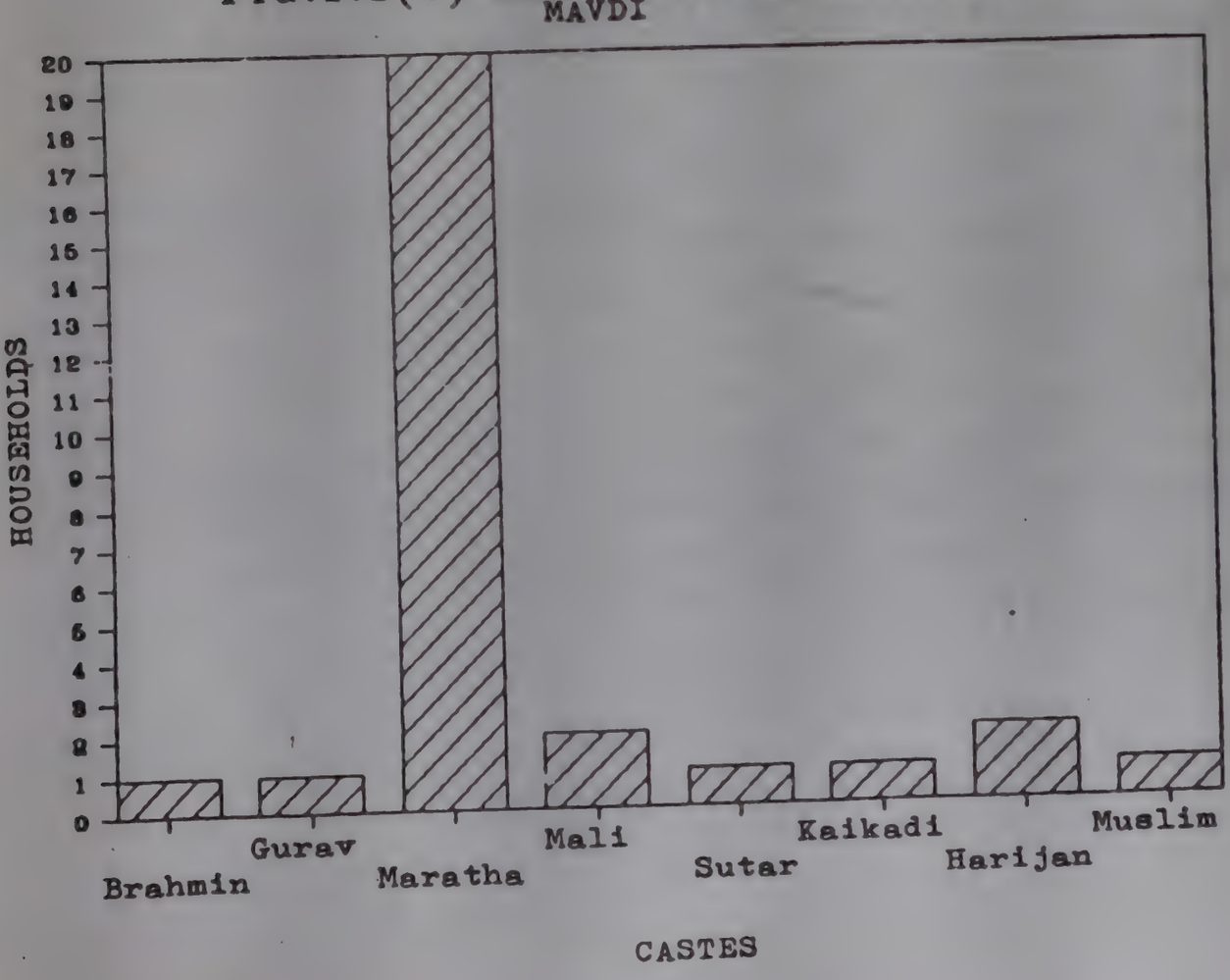


FIG.1.2(a) PER CAPITA INCOME
PONDHE

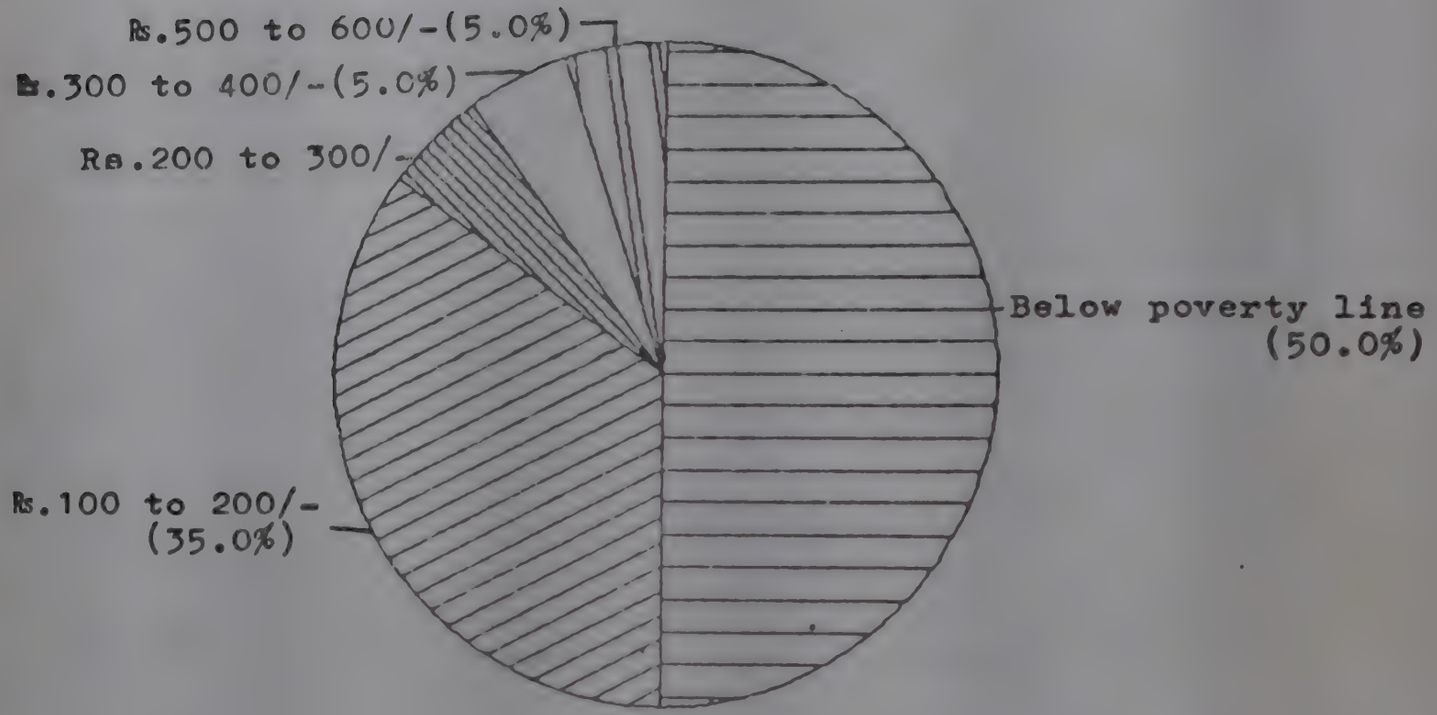


FIG.1.2(b) PER CAPITA INCOME
MAVDI

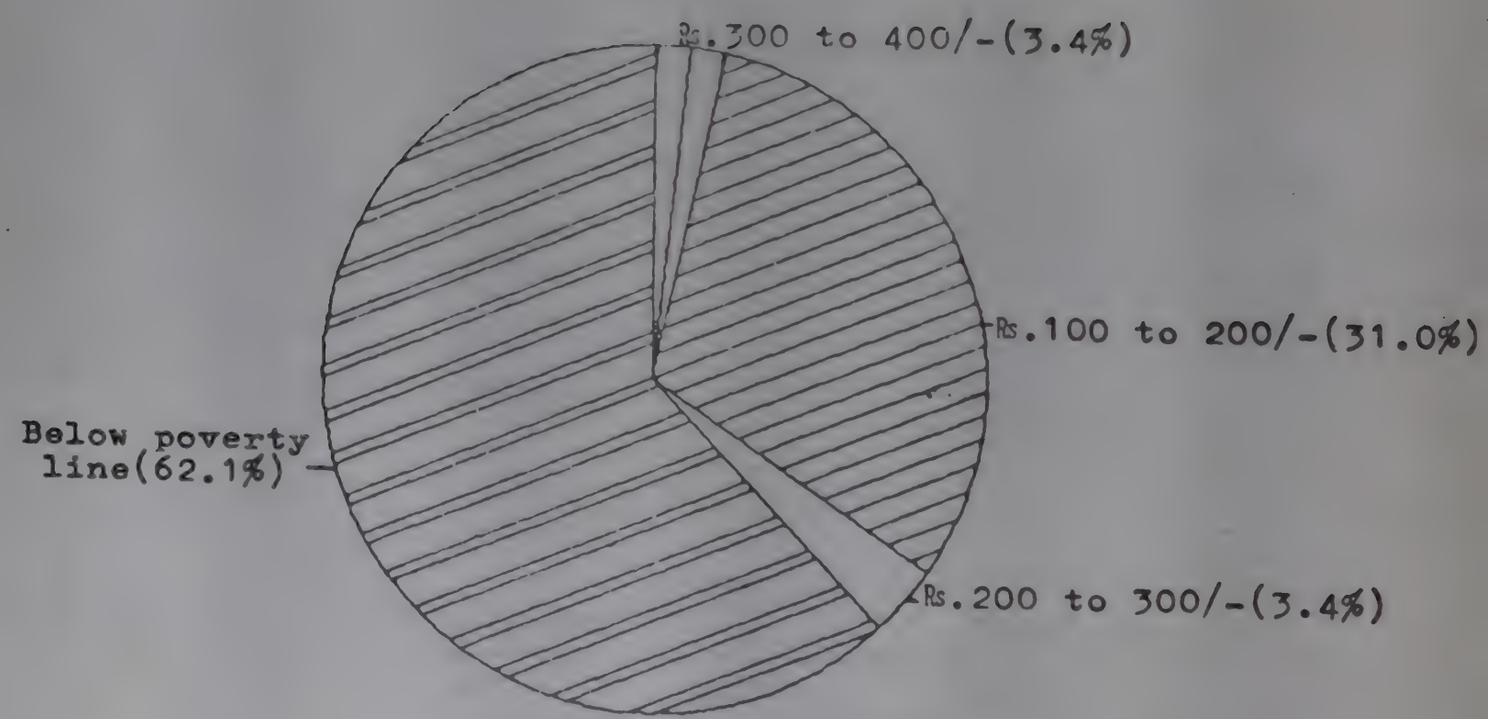


FIG.1.3(a) HIGHEST LEVEL OF EDUCATION
IN THE HOUSEHOLD : PONDHE

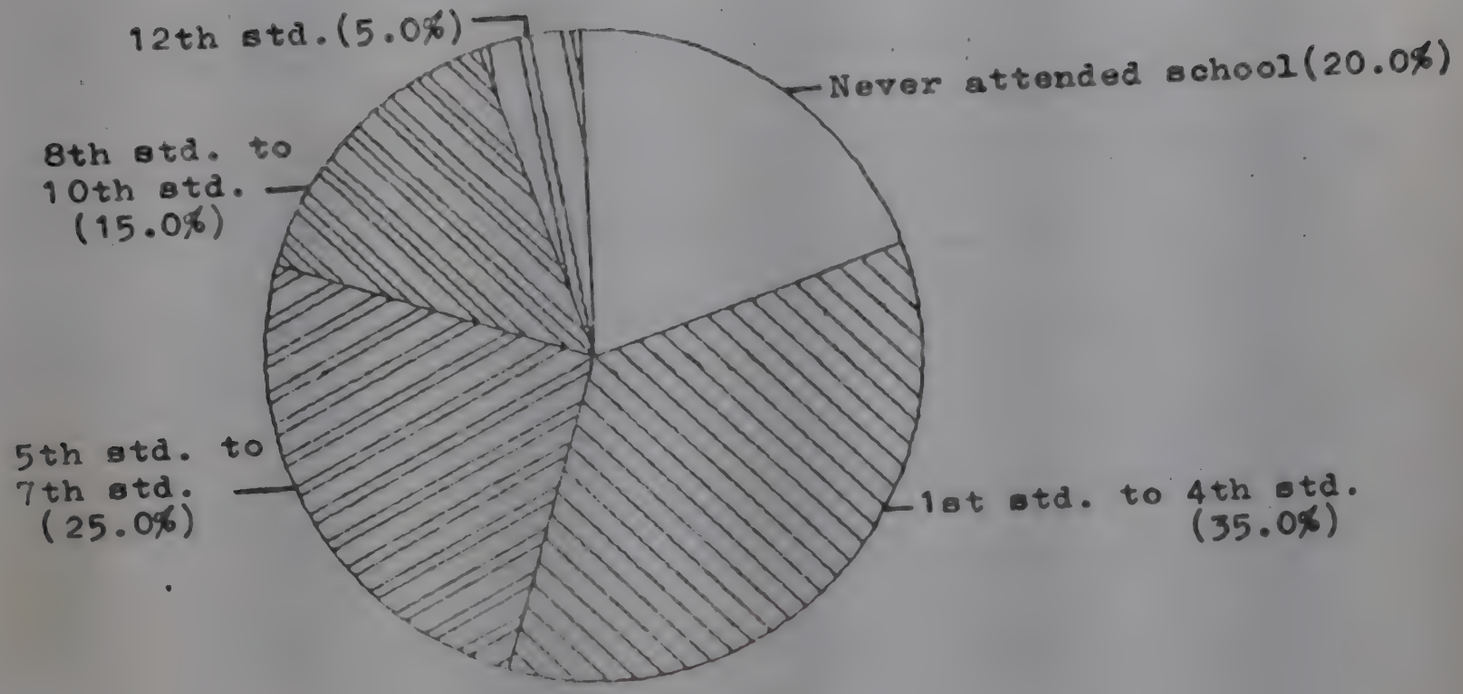
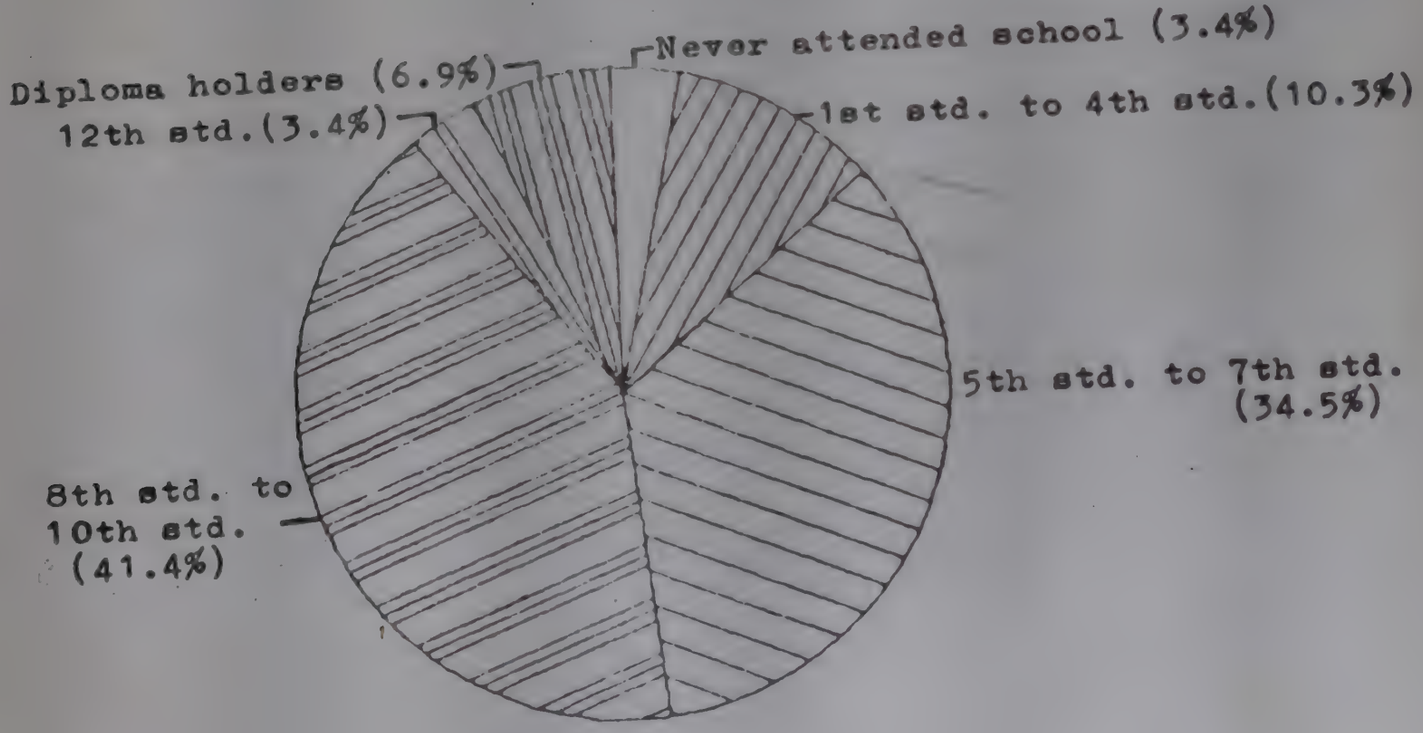


FIG.1.3(b) HIGHEST LEVEL OF EDUCATION
IN THE HOUSEHOLD : MAVDI



CHAPTER - 1

Tables

Table: 1.1 Household Structure

Household Structure	Pondhe	Mavdi
	Households	Households
Joint Households	7 (35)	13 (45)
Nuclear Households	13 (65)	16 (55)
Total Households	20 (100)	29 (100)

Note: Figures in paremthesisindicate percentages.

Table: 1.2 Family Size by Household Structure

Family Size	Pondhe		Mavdi	
	Nuclear households	Joint households	Nuclear households	Joint households
Upto 2 members	5 (38)	-	-	-
3 to 5 members	7 (54)	1 (14)	13 (81)	1 (8)
6 to 9 members	1 (8)	3 (43)	2 (13)	7 (54)
10 to 13 members	-	2 (29)	1 (6)	5 (38)
More than 13 members (one household of 19 members)	-	1 (14)	-	-
Total households	13 (100)	7 (100)	16 (100)	13 (100)

Note: Figures in parenthesis indicate percentages.

Table: 1.3 Landholding Pattern by Household Structure

	Pondhe		Mavdi	
	Nuclear households	Joint households	Nuclear households	Joint households
Landless households	1 (8)	-	1 (6)	1 (8)
Small farmers	8 (61)	2 (29)	7 (44)	2 (15)
Middle farmers	4 (31)	-	7 (44)	4 (31)
Large farmers	-	5 (71)	1 (6)	6 (46)
Total households	13 (100)	7 (100)	16 (100)	13 (100)

Note: Figures in parenthesis indicate percentages.

Table: 1.4 Distribution of Individuals by Age

Age - Group	Pondhe	Mavdi
	Individuals	Individuals
Less than 1 year	2 (1)	3 (2)
1 year to 4 years	9 (7)	24 (13)
5 years to 14 years	30 (25)	34 (18)
15 years to 24 years	14 (12)	31 (16)
25 years to 34 years	27 (22)	31 (16)
35 years to 44 years	6 (5)	14 (7)
45 years to 54 years	14 (12)	16 (8)
55 years and above	19 (16)	38 (20)
Total individuals	121 (100)	191 (100)

Note: Figures in parenthesis indicate percentages.

Table: 1.5 Marital Status of Individuals

Marital Status	Pondhe		Mavdi	
	Individuals		Individuals	
Never married	50	(41)	81	(42)
Currently married	66	(55)	95	(50)
Deserted	-	-	1	(0.5)
Separated	1	(1)	4	(2)
Divorced	-	-	1	(0.5)
Widowed	4	(3)	9	(5)
Total individuals	121	(100)	191	(100)

Note: Figures in parenthesis indicate percentages.

Table: 1.6 Landholding Pattern of Households

	Pondhe		Mavdi	
	Percent Household	Percent of land	Percent Household	Percent of land
Landless households	5	-	7	-
Small farmers	50	12	31	12
Middle farmers	20	32	38	18
Large farmers	25	56	24	70

Table: 1.7 Landholding Pattern by Caste

	Pondhe					Mavdi				
	*L.L.	S.F.	M.F.	L.F.	T	L.L.	S.F.	M.F.	L.F.	T
Brahmin	-	-	-	-	-	-	1	-	-	1
Gurav	-	-	1	-	1	-	1	-	-	1
Maratha	-	6	3	4	13	-	2	11	7	20
Mali	-	1	-	1	2	-	2	-	-	2
Sutar	-		-	-		1	-	-	-	1
Dhangar	-	1	-	-	1	-	-	-	-	-
Ramoshi	-	1	-	-	1	-	-	-	-	-
Kalkadi	-	-	-	-	-	1	-	-	-	1
Harijan	1	1	-	-	2	-	2	-	-	2
Muslim	-	-	-	-	-	-	1	-	-	1
Total	1	10	4	5	20	2	9	11	7	29

* L.L. : Landless
S.F. : Small farmers
M.F. :: Middle farmers
L.F. : Large farmers
T : Total.

Table: 1.8 Irrigated Land

Percentage of irrigated landholding	Pondhe Households		Mavdi Households	
	No.	(%)	No.	(%)
Nil	17	(85)	9	(31)
Upto 20% of landholding	3	(15)	18	(62)
20% to 40% of landholding	-	-	2	(7)
Total households	20	(100)	29	(100)

Note: Figures in parenthesis indicate percentages.

Table: 1.9 Percentage of Irrigated landholding

Irrigated land	* L.L	S.F	M.F	L.F	T	L.L	S.F	M.F	L.F	T
Total households	1	10	4	5	20	2	9	11	7	29
Upto 20% irrigated landholdings	-	1	1	1	3	-	2	10	6	18
20% to 40% irrigated landholdings	-	-	-	-	-	-	1	-	1	2
% of households with irrigated land	0	10	25	20	15	0	33	91	100	69

* L.L = Landless; S.F = Small farmers; M.F = Middle farmers; L.F.= Large farmers; T = Total.

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Table: 1.10 Monthly Household Income

Monthly Household Income	Pondhe		Mavdi	
	Households		Households	
Below Rs.100/-	2	(10)	3	(10)
Rs.100/- to Rs.250/-	2	(10)	4	(14)
Rs.250/- to Rs.500/-	6	(30)	8	(28)
Rs.500/- to Rs.1000/-	6	(30)	9	(31)
Rs.1000/- to Rs.2000/-	4	(20)	4	(14)
Rs.2000/- & above	-	-	1	(3)
Total	20	(100)	29	(100)

Note: Figures in parenthesis indicate percentages.

Table: 1.11 Level of schooling by Sex

Level of schooling	Pondhe				Mavdi			
	Males		Females		Males		Females	
Illiterate	17	(25)	30	(56)	15	(16)	47	(48)
Only literate	1	(2)	1	(2)	1	(1)	-	-
1st Std. to 4th Std.	29	(43)	13	(24)	31	(33)	15	(15)
5th Std. to 7th Std.	9	(13)	6	(11)	18	(19)	16	(16)
8th Std. to 10th Std.	3	(5)	-	-	15	(16)	1	(1)
12th Std.	1	(2)	-	-	2	(2)	-	-
Diploma Holder	-	-	-	-	2	(2)	-	-
N.A. (below 5 yrs.)	7	(10)	4	(7)	10	(11)	18	(19)
Total	67	(100)	54	(100)	94	(100)	97	(100)

Note: Figures in parenthesis indicate percentages.

Table 1.12 Level of Schooling by Age

Level of Schooling	Pondhe			Mavdi		
	5-14 years	15 years & above	Total	5-14 years	15 years & above	Total
Never attended school	5 (17)	44 (55)	49 (41)	3 (9)	60 (46)	63 (33)
1st to 4th Std.	19 (63)	23 (29)	42 (35)	17 (50)	29 (22)	46 (24)
5th to 7th Std.	5 (17)	10 (12)	15 (12)	13 (38)	21 (16)	34 (18)
8th to 10th Std.	1 (3)	2 (3)	3 (2)	1 (8)	15 (12)	16 (8)
12th Std.	-	1 (1)	1 (2)	-	2 (2)	2 (1)
Diploma Holder	-	-	-	-	2 (2)	2 (1)
N.A. (below 5 years)	-	-	11 (9)	-	-	28 (15)
Total individuals	30(100)	80(100)	121(100)	34(100)	129(100)	191(100)

Note: Figures in parenthesis indicate percentages.

Table: 1.13 Educational Status of the Head of the Household

Level of Schooling	Pondhe Households		Mavdi Households	
Illiterate	9	(45)	12	(42)
Only literate	1	(5)	1	(3)
1st Std. to 4th Std.	8	(40)	12	(42)
5th Std. to 7th Std.	2	(10)	13	(10)
8th Std. to 10th Std.	-	-	1	(3)
Total	20	(100)	29	(100)

Note: Figures in parenthesis indicate percentages.

Table: 1.14 Distribution of Electricity by Socio-Economic Strata

Socio-Economic Strata	Pondhe		Mavdi	
	Total Households	Households with Electricity	Total Households	Households with Electricity
High	1	-	1	1 (100)
Middle	12	1 (8)	23	8 (35)
Low	7	-	5	2 (40)
Total	20	1 (8)	29	11 (38)

Note: Figures in parenthesis indicate percentages.

Table: 1.15 Loans : Purpose and Amount

Amount of loan	Pondhe			Mavdi		
	Con-sump-tion	Pro duc-tion	Total	Con-sump-tion	Pro-duc-tion	Total
Upto Rs.1000/-	2 (40)	-	2	2 (11)	-	2
Rs.1000/-to 2000/-	1 (20)	-	1	3 (18)	-	3
Rs.2000/- to 5000/-	1 (20)	-	1	8 (47) (89) *	1 (33) (11) *	9
Rs.5000/- to 10,000/-	-	-	-	3 (18)	-	3
Rs.10,000/- to 15,000/-	1 (20)	-	1	-	-	-
Rs.15,000/- & above	-	-	-	1 (6) (33) *	2 (67) (67) *	3
Total	5 (100) (100) *	-	5 (100) 25% of sample	17 (100) (85) *	3 (100) (15)	20 (100) 69% of sample

Note: Figures in parenthesis indicate percentages.

* Figures in upper parenthesis indicate column percentage and figures in the lower parenthesis indicate row percentage.

CHAPTER - 2

WOMEN'S WORK AND OCCUPATIONAL HEALTH

Prologue

This chapter deals with the various kinds of work that the residents of Pondhe and Mavdi were involved in. Since women formed the major subject of our study, we have highlighted upon the kinds of activities, paid and non paid, that women are involved in thrcugh the day and through the year. We are aware that in the absence of sophisticated techniques to measure work output, it is not possible to express the latter in quantifiable terms. However, that is not the objective of the present study.

Through this study involving the respondents of our structural schedule, and more importantly our case studies, meetings with village women at EGS sites and in the village, we want to strengthen the discussion on the concept of women's work. We feel that a serious challenge to the existing concept is necessary, wherein not only are all non paid activities dismissed as 'non work', but even the wage earning activity of women is considered as supplementary to the household income.

Since our definition of women's work fell outside the traditional fold, we were left to deal with this topic in a non-traditional manner. In this chapter therefore we present a qualitative and quantitative account of women's labour, the occupational hazards of wage labour and the chaos that they create in women's lives. Since women also perform social labour such as domestic work, reproduction and child rearing, often these hazards are not strictly caused, but are only enhanced by

wage labour. In the absence of a true understanding of women's multifold contribution to society, women get further victimised by not receiving compensations at the work site for the illnesses that they present. Therefore, symptoms such as anaemia, weakness and backache being universally present in most poor women, are not considered "occupation related".

Such compartmentalisation will exist as long as all of women's work does not become visible. We feel that the invisibility of women's labour is linked to the fact that most of women's work is considered private and personal. It is only when domestic labour, reproduction and child rearing get the status of economically productive labour, which in our view they necessarily are, that women's work will become visible.

Work characteristics of respondents:

The two villages, Mavdi and Pondhe, have an agriculture based economy. Even though agriculture (cultivation of one's own field) was reported as the single main occupation in both the villages, the data depicts that more than one-fourth of the total population (29% in Pondhe and 31% in Mavdi) were engaged in some or the other kind of wage labour (Table 2.1). At the time of data collection (month of July), agricultural work had still not started due to the non-arrival of the monsoons and hence it is possible that more people were engaged in non-agricultural, wage labour activities.

In Mavdi there were six males who were "balutedars" and one of these combined agriculture and balutedari. The other five balutedars were Sutars (carpentars) who besides

balutedari also used their carpentry skills for income generation. Though 15 men (48%) in Mavdi attended EGS work, of these 13 males were also engaged in agriculture. For these men, EGS provides a supplementary income to the main agricultural activity. In Mavdi, three males were also self-employed and two of these were again engaged in agricultural production.

Of the four respondents who reported "service" as their occupation in Mavdi, three were males. One was a primary school teacher, the second respondent was a regular wage earner at a flour mill in the village, and the third respondent was working in a factory as an apprentice to an electrician. The fourth respondent, the only woman who reported "service" as her occupation, was a teacher in a village Panchayat managed balwadi (pre-school kindergarten).

In Pondhe, both the respondents in the "service" category, were employed as permanent labourers in a masala (spice processing) mill in Yewat. Each earned Rs.300/- per month and in this factory, the workers had recently unionised to demand for better wages.

Significantly enough, the data showed that the female wage earners outnumbered the male wage earners. There were 102 female wage earners for every 100 male wage earners, in the sample population. (Table:2.2). However, not a single woman was unionised at the work site. All the women worked in the unorganised sector.

Employment Guarantee Scheme (EGS)

(Details about EGS in Purandar taluka are attached at the end of this chapter.)

Two-thirds of the total wage earners in Mavdi and Pondhe were employed as EGS labourers, signifying that EGS work was the main mode of wage labour in the two villages (Table: 2.3). Almost all the female wage earners from our sample (100% in Pondhe and 86% in Mavdi), were employed as EGS labourers. (Table: 2.4)

More often than not, women prefer to work as EGS labourers because it is guaranteed wage labour unlike "majoori" (labour). Also there is a clear disparity between the wages earned by men and women workers in private majoori (men earn Rs.15/- per day, whilst women earn Rs.7/- per day). Many a times, the wheat coupons are an added incentive in EGS labour and therefore at least one member per family is encouraged to go for EGS work. However, men themselves prefer private majoori to EGS labour as it fetches them higher wages. In Pondhe, the majority of the male wage earners go to Yewat village on the Pune Solapur highway (5 kms. downhill from Pondhe), where there is a demand for private majoori because of canal irrigated land and commercial establishments.

A joint study conducted by the Programme Evaluation Organisation, Planning Commission, Government of India and the Directorate of Economics and Statistics, Government of Maharashtra (Joint Evaluation Report on EGS of Maharashtra, June 1980), supports our data that on an average women always outnumber men on EGS sites. The above study was

conducted in four districts namely, Nashik, Solapur, Beed, Bhandara, representing all the three regions (Western Maharashtra, Marathwada and Vidarbha) and two talukas per district were considered. A total of 155 villages, 244 EGS works and 3404 beneficiary households, were selected. Data collected in four rounds during April 1976 and October 1978, from muster rolls in respect of 19,006 workers in selected 25 works in progress were analysed, and it was seen that 45% of the work force was male, whereas 55% was female. (Article 7.38, page 43).

As of September, 1987, on the 77 works on EGS in progress in Purandar taluka, 67% of the work force was female and 33% was male. (See annexure I at the end of this chapter).

In our own study we found that an even higher percentage of the EGS work force is female. The muster rolls at Pondhe and Mavdi on the days of our meetings showed 78% and 85% of the work force respectively to be female. We believe that though many men are registered on the muster roll as EGS workers, they actually send their wives to the site while they go in search of work with higher wages.

Another reason why male members go in search of non EGS labour in spite of the assurance of minimum wages, could be that especially for landless labourers who live from hand to mouth, it might not be possible to wait for weekly or fortnightly payments. The household therefore may be forced to work at sites where payment is made at the end of every day. These were the findings of the earlier mentioned government report on EGS. (Article 7.37, page 43).

EGS works in Pondhe and Mavdi:

According to the conversation with Shri Sable, Agricultural Assistant at the EGS site in Pondhe, there are 1134 hectares of land in Pondhe out of which 600 hectares is fallow land.

"When a nalla has to be bunded there shoild be at least 100 hectares of catchment area. Once the area is surveyed and selected, the exact spot and details of the nalla are planned (height, length width) and then duration of work is estimated. The EGS mukadam then takes over."

EGS work completed, (Department of Soil Conservation) at Pondhe:

Until now, on EGS the following work has been completed in Pondhe.

1) The Pondhe - Malshiras road
2) The Pondhe - Rajuri road.
3) The Pondhe - Yewat road (incomplete).
4) 24 nallas because of which wells in Pondhe have received water.

EGS work completed, (Department of Minor Irrigations) in Mavdi:

1) The biggest Paazar Talav (percolation tank) in Mavdi was built during the 1972 famine. That lake is full today even though there have been only a few showers in August 1987.

2) Breaking of stones for all major road works.
3) The Mavdi Kothale road
4) The Ambewadi Mavdi road (3 kms.)
5) The Mavdi Chaufule road (5 kms.) constructed through EGS, now under Zilla Parishad.
6) Around 10 nallas were bunded in and around Mavdi village.

Details about availability of employment

Details regarding the availability of employment during the year were asked to find out the extent of employment and under-employment in the area. Respondents were not able to articulate the actual number of days on which employment was available to them throughout the year. The reasons for this could be many.

i) EGS itself is a temporary employment (based on various works identified by the eight departments of the State Government).

ii) Women are not aware of planning and the duration of work at EGS sites.

iii) Basically both the villages are part of agricultural society and so EGS is perceived merely as a stop-gap before they return to the fields.

iv) Though many respondents expressed agriculture as their occupation, because of drought we could not get authentic data regarding the actual number of days' work that their fields provided during the past one year. This probably is typical to drought areas where there is nothing to grow on one's own

fields. There is no question of taking three crops when even the main Kharif crop is uncertain.

In spite of collecting all this data through our structured interviews we found that we could not make any relevant comments on the extent of employment of the population and therefore that data is not presented quantitatively.

In Pondhe 55% of the wage earners while in Mavdi 62% of the wage earners were found to be working on the EGS sites for more than three months. These figures throw some light on the severity of the drought in the region. Those respondents who reported employment for the full year were those working in factories as daily wage earners or those who were balutedars. cattle herders, petty shop owners or artisans. On EGS sites people worked for as long as that particular project lasted. Those respondents who were exclusively cultivators were severely under utilized in terms of their working capacity, due to persistent drought. The other cultivators turned either to private majdoori (mostly the men) or to EGS (mostly the women), when there was no work in their own fields.

The level of education of the wage earners in our sample does not seem to affect the choice of wage-labour. We find that the majority of those who have had primary and secondary (up to 7th Std.) education were working as EGS labourers. (Table: 2.5)

Wage-Earnings

The EGS workers receive weekly wages which include payment in cash as well as kind (wheat coupons). Those employed as private majdoor and agricultural labourers

get daily wages, while those in service earn a monthly income. The cattle herders derive an annual income through the sale of wool, cattle and goats' milk.

Average Monthly Income

Type of Wage Labour	Pondhe	Mavdi
Agricultural labour	Rs.450/-	Rs. 75/-
EGS workers	Rs.204/-	Rs.134/-
Private 'majdoors'	Rs.394/-	Rs.398/-
Service	Rs.380/-	Rs.600/-
Cattle herders	Rs.170/-	Rs.300/-
Self employed	--	Rs. 50/-

Source: Sample data

Though female wage earners outnumber their male counterpart we find that a vast majority of the female wage earners earn less than Rs.300/- per month (Pondhe - 95% and Mavdi - 96%) as compared to the male wage earners (Pondhe - 30% and Mavdi - 84%). In both the villages (Table: 2.6) the disparity amongst the wages earned by the male and female wage earners is more striking in Pondhe than in Mavdi because majority of the men engaged as private majdoors earn higher wages than are possible through any of the other forms of available wage labour.

Table 2.7 presents the contribution of women's wages to the monthly monetary household income. The data depicts that in 40% of the households in Pondhe, the women did not contribute to the monetary household income. The women from these households nonetheless worked in their

fields as well as catered to the domestic needs of their household. In 5% of the households in Pondhe, women contributed up to one-fourth of the monetary household income while in as many as 20 of the households women's contribution amounted up to half of the monetary household income. In 5% of the households in Pondhe, women contributed up to 75% of the monetary household income whereas in 30% of the households, the entire monetary income of the household was the women's contribution.

While in 38% of the households in Mavdi, women did not contribute to the monetary income of the household, in 10% each of the households in Mavdi contributed up to one-fourth and half of the monetary income. In as many as 28% of the households, women contributed up to 75% of the monetary income and in 14% of the households, the contribution of women was hundred percent.

The above data as well as our qualitative findings clearly reveal that around in 20% of the households. the women are responsible for the entire monetary income. Another 20% households are supported more than 50% in terms of money by the women every month.

It is noteworthy that in spite of women being paid half as much as men are, in the final analysis, they support more than half of the households' monetary income in at least 40 households out of 100. It is important to note that except in one household out of 49, in our sample, there was always an adult male member.

Facilities at work-site:

Amongst all the wage earners, only the EGS workers reported to have been provided with facilities at the work-site which included drinking water, first-aid kit and a shed. During our visit at the EGS site in Mavdi, however, we observed that during the lunch hour, it was only the men who were resting inside the shed (a cover with one and half walls of straw), whilst all the women workers were outside the shed in the sun. Arrangement for a creche was also made at the Mavdi EGS site but surprisingly none of the workers reported it as a facility in the schedules. There was no creche at the Pondhe EGS site, but in Mavdi we saw about eight children in the shed. They were looked after by an old woman who worked as a dai on the EGS site. She was paid Rs.4/- per day along with the daily quota of wheat.

Drinking water at the EGS site is stored in large metal drums. Normally, some bullock cart owner is paid Rs.25/- per day to make as many trips as necessary from the water source to the EGS site. It is the grampanchayat's responsibility along with the Primary Health Centre to regularly disinfect this water. We do not know how regularly throughout the year, this is done, because often the TCI stocks are inadequate and also people are disinclined to drink chlorine treated water because of the pungent odour that it imparts.

A first-aid kit contains tincture iodine and some bandages to deal with injuries. Stocks of pain relievers may not always be replenished.

Benefits and Compensations:

Though the government circular of December 1983 (Annexure I), clearly states that certain benefits are available for EGS workers, we found none of these were implemented at the grass roots. In both villages, we did not find a single woman who had either availed or heard of monetary benefits after delivery, sterilisation or accident at work site. The government circular provides no compensation for abortions at work site.

On the day of the women's meeting at the Mavdi EGS site, there were 5 pregnant women in the group. The women said that there were no benefits for pregnant women at the EGS site. No TT injections were given and not a single woman until now had availed of maternity leave or benefits. 'If a pregnant woman works in the morning and if she delivers in the afternoon, her entire day's wages are deducted because she did not return in the afternoon', the women said. The women complained that no proper first aid was available.

One month ago at the EGS site in Pondhe, a four months pregnant woman (her first conception) suddenly got cramps in her stomach while lifting a head load of mud. She was taken home and she aborted. It was a late first conception, because the woman looked to be around 32-35 years of age. She resumed duty within a few days because "there was no choice. The daily wage cannot be foregone". The doctor (private practitioner) who attended to her said: "You lift loads. All else was fine. Work caused the miscarriage!"

The other women said that they had all worked during pregnancy, often until the last week or day. They returned

to EGS work after one or two months of delivery. "In our village since land is not irrigated, there is no income for women except EGS. Our life is spent digging, lifting, carrying and dumping mud. Is there a choice for any of us, even if our health and babies are affected?" Not a single woman said that she had received any maternity benefits. They were surprised to hear that these benefits existed for their sakes.

We told them about the agricultural assistant's perception about the maternity benefits that "if a pregnant woman who is on the muster delivers, then the rest of her group has to bear her income. A pregnant woman can stay at home even after the seventh month if she so pleases. Her share is calculated from her group's weekly work and then she is paid." About this the entire group expressed resentment because their daily wage is reduced. They said: "Why should we pay a delivering woman out of our own pockets? If the government is concerned about her health, she should be paid independently".

At the EGS site in Pondhe, there were women of all ages above the age of 14 years. There were 6 pregnant women present and two of them were eight months pregnant. Some of them had breast feeding infants at home. None of the women had brought their infants to work because there was no dai. All of them went home to breast feed their babies every afternoon during the lunch break. The EGS site is a little more than 1 km. away from the village.

At the EGS site in Mavdi, we learnt that a few days ago, the woman had fallen from a height and had badly hurt herself. She was taken to a private practitioner in Saswad, in a state of shock. She had not heard anything about

monetary compensation. When the women started discussing her case, there was a divided opinion. Some said that she was eligible for compensation while the others maintained that since she had taken private treatment she was no longer eligible. None of the women were aware of details regarding compensation.

Occupational Health:

As mentioned in the earlier part of this chapter, it is difficult to prove the etiological relation of women's wage earning occupation to their general physical and mental condition. Often women present very general symptoms which are more a reflection of drudgery and poverty. We encountered similar problems in our study. Another factor that women could clearly relate to their bodily deterioration was tubectomy. The women vividly expressed that their daily workload and tubectomy made physical wrecks out of them.

Speaking of occupational hazards the women at the Pondhe EGS site, complained of severe bodyache due to fatigue, cramps in feet, injuries due to outdoor work on nalla bunding and fuel collection, scorpion bites due to the same, and blinding headaches due to constant exposure to the sun.

Aches and pains (backache, bodyache, headache, abdomen ache and joint ache increaseng with age) were the common complaints. Some listed minor injuries as a complaint. A large number of women complained of leucorrhoea. Many attributed leucorrhoea and backache to sterilisation.

The women in Mavdi suffered from and associated the foll wing ailments with their work on EGS sites:

> Stomachache, joint ache, shoulder joints pain, (more with older women,) cramps in feet, weakness, giddiness, migraines and splitting headache, pain in the region, backache (mainly they complained of pain below the waist region - so much so that "We can't sit on the floor and touch our backs to the floor").

Because of these body pains, women said that they couldn't walk fast. Some women complained of not being able to digest the food that they ate. When younger women (18-20 year old daughters-in-law of the village) complained of bodyache and tiredness, the older women said: "You are new to work, that's why it hurts more". Those who had backache said that for those who were sterilised, backache was much worse.

Surprisingly, when health practitioners were questioned about occupatonal health of women, they could not associate any ailment with specific occupations. They did not report any seasonal variation in problems specifically related to women such as spontaneous abortions.

Perception about work:

The work:

For the womenfolk in the village, the day begins at dawn. The first task is to collect firewood from the village. As days pass, the search for firewood takes the women further on in the almost desert like landscape, since this exhaustable resource is difficult to replenish due to the drought situation.

No sooner do they reach home with the firewood than they have to set out again to fetch water. A minimum of three trips to the well (situated on the outskirts of the village) are necessary to fulfil the requirement of water for the household. Many a times, the girls help their mothers in this chore.

Only after the women have swept the house, the yard and the cowshed and have washed clothes, can they settle down to cooking the first meal of the day. The meal has to be ready by nine o'clock in the morning.

Most of the women wage labourers have to attend to all these domestic chores before leaving the house by 9.30 a.m., to enable them to reach the work site by 10.00 a.m. For those who do not have any elderly women or adolescent girls at home, an additional burden of attending to the needs of the younger children (bathing and feeding them) is imperative.

The one hour mid-day break is just enough for the women to return home for meals, cleaning the utensils and to report back for work.

After a hard day's labour at the work site, the evenings hold more work in store for her, in the house. More often than not, the women rush to the well to replenish the stock of water, following which they start cooking a full meal for the family.

The women are usually the last to eat dinner in the dinner in the house. Only after she has cleaned the utensils and cleared the kitchen, can she finally call it a day.

The women are also actively involved in repairing, maintaining and constructing the house. On alternate days the woman has to plaster at least some part of the house, (a room, the cowshed, the backyard), with a mixture of mud, cowdung and water. Each floor requires such a plaster every week. Once in three months the women plaster all the walls of the house, both from the inside and outside. They repair the mud stoves (chulha). Animals, if any, have to be washed and fed daily. They have to be let out for grazing and have to be tied in the cowshed every day. Goats, sheep or poultry also require similar care. Animals also require fresh fodder which has to be constantly collected.

All these jobs continue throughout a woman's life, from early childhood to death. Women seldom "retire" from work. The above-mentioned responsibilities are performed all through pregnancy and begin within a fortnight of the delivery.

The perception:

Ironically, women could not articulate the vivid aspects of their labour and also had a low self-perception about their own work. They did not see the magnitude of their work and accepted the over-burdening as a fact of life.

Not a single woman respondent could enumerate her rights as a worker. Her perception of her wage labour was pragmatic. "We are wage labourers out of compulsion. We have no rosy dreams about what we ought to be doing or what our daughters should do. Had it not been for nagging

poverty and drought we would all prefer not to spend day after day in the scorching sun for a few rupees. If it rains we will all return to our own fields."

Women strictly believed that the man was superior. When asked as to why they opted for tubectomy, when vasectomy was less hazardous and was much easier to perform. They said: "Our men have to work hard. We cannot allow them to become weaklings. Sterilisation drains a person of all energy for life. That is why tubectomy is preferable. What work do women do anyway?"

The patriarchial structure of the village community would fuel this low self perception among women. Wife-beating, bigamy, desertion of women and alcoholism are rampant in this area. Besides constantly affecting women's physical and mental health, battling with these day to day oppressions would not naturally allow a woman to become self-confident.

In a group meeting in Mavdi, one woman said that alcoholism was a big problem that women faced here and so was wife-beating. In many cases wife-beating was independent of alcohol consumption by the husband. There are no alcohol shops in Mavdi, but people drink from neighbouring villages such as Pimpri and Pisarve. A young girl remarked that she had once taken an evening bus from Pisarve and the whole bus was full of drunken men. One young man from their village had some time ago died on the railway track after consuming alcohol. The women said that they were sick of having to deal with drunken husbands after a hard day's work at the EGS site, in the farm or at home, but that they had no choice except

to bear it.

The younger women, especially school going girls, expressed that they had become misfits, neither possessing their monthers' domestic skills nor being able to see a way out of this drudgery.

School going girls in Pondhe said that they were not as good in the fields as their mothers were. Though they performed small jobs in the field like weeding, they didn't do heavy jobs. But they were all reconciled to the fact that they would be married into farmer households (joint families, too) and would have to do hard domestic labour.

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ANNEXURE I

Details about EGS activity in Purandar taluka:
(Compiled by Dr. Ramesh Awasthi)

The government of Maharashtra launched EGS in May 1972. However, until 1973-74, enormous programmes of scarcity relief were still under way and so in December 1974, the State Assembly approved the Government Recommendation (GR) reiterating its recognition of the right to work as enunciated in the Directive Principles of the Constitution of India. EGS was given the statutory status in January 1979. (Joint Evaluation Report on EGS of Maharashtra, June 1980).

1. EGS was initiated in Purandar taluka in 1974-75. Before 1974 (i.e. in 1971-72) relief work was undertaken under some other schemes. (Drought relief works).

2. EGS is undertaken through eight departments which include minor irrigation (percolation tanks), afforestation, soil conservation (nalla bunding) and construction activities that include road building.

3. As on 11.9.87, the EGS work in Purandar Taluka was as follows:

Pwrcolation tanks	-	18
Nalla bundings	-	39
Afforestation	-	13
Roads	-	7
		77

(In May and June there were 103 works going on.)

4. Total labour capacity - 7937 persons

Attendance presently :

male	-	2390 (32.9 %)
female	-	4877 (67.1 %)
total	-	7267 (100 %)

5. Benefits available as per circular of December 1983 (still valid).

A. Maternity benefits:

A woman who has worked for at least 150 days during a period of one year preceding the first day of absence from EGS work (on account of maternity) gets Rs.6/- per day for 30 days (i.e., Rs.180/- per month, paid in one lump sum) irrespective of the number of children. A medical certificate from the PHC/PHU is necessary.

B. Benefits after sterilisation:

Tubectomy - 14 days paid leave at the rate of Rs.6/- per day.

Vasectomy - 7 days paid leave at the rate of Rs.6/- per day.

C. Compensation benefits:

Death by accident - Rs.5000/-

Non-fatal accidents - Rs.6/- per day and all expenses during the hospitalisation period.

There is no compensation for abortions that may occur on EGS sites or due to EGS work.

Annexure II

Interview with Shri B.V.K., EGS mukadam at Pondhe. (Age - around 35 years).

Background:

Babasaheb is a resident of village Pondhe. He has 8-9 acres of non-irrigated land. We has been an EGS mukadam for 8 years now. He gets weekly wages working to around Rs.12/- per day and a quota of wheat, like the other workers. His job is to supervise work, measure work output, work out weekly wages for each group and individual and guide the construction activity on the basis of the plan prepared by his supervisors.

Work and Wages:

Five to seven persons constitute one group. They work together and each day their output in terms of square metres is calculated. The consistency of soil determines the wages, as does the distance and height that the workers have to cover to dump the soil.

The wages are as follows:

One square metre of muddy soil	Rs.2.75
Highest rate/sq.m. (More than 50% stone contents)	Rs.5.98

Additional wages:

1) Walk -	from 10-80 metres	Rs.0.70
	from 80-150 metres	Rs.0.80
2) Climb -	1 metre to 5 metres	Rs.0.85
	5 metres to 10 metres	Rs.1.03

3) Wheat - 1.400 Kg. per person daily (400 gms is free. 1.0 kg. is sold at the rate of Rs.1.55/kg., and that amount is deducted from the wages daily.)

If five people constitute a group, their work output on an average is 20-30 sq.metres per week. The weekly wage per individual is calculated. Daily wage is calculated for deduction if a person has been absent for a day or days. There is no particular day of the week when wages are paid. The maximum payment an individual can draw per week is Rs.35. It has never been more. Sometimes the wages work out to Rs.20 per week per person especially if the terrain is rocky or hilly.

The present attendance on the muster is 87 persons, out of which 68 are women. In non agricultural seasons the attendance is around 105-110 and during days when sowing and ploughing is done, the attendance falls to 50. On all days women constitute 70-80 percent of the work force. 'That is because men cannot afford to work on these paltry wages. They go to Yewat and other places in groups and take individual or group contracts with big farmers. There the land is irrigated. They all work with mud even in Yewat but there they can earn up to Rs.15-20 per day. Besides the fact that women find work and supplement their men's wages, what is lucrative about EGS is the weekly quota of wheat. At least the family does not have to sleep on an empty stomach for lack of grain'.

Earlier, most of the EGS work was road construction. Nine months ago the present nalla bunding work began. Sometimes there is a time gap between two constructions, ranging from 6-10 months and during this period people have no EGS employment.

Health & Hazards:

Babasaheb has noticed that joint ache, body ache, ache in the 'bones' among older workers and fevers are commonly the health hazards on an EGS site. 'Especially in Pondhe, illness is a big problem. The patient has to be put into a cloth 'doli' and carried down the mountains to a private practitioner. Otherwise they have to walk 7 kms. to Malshiras PHC. Pondhe is so inaccessible that even daughters, who are married outside the village cannot come here for years together. How can they walk up the lonely hill range along with little children?' When asked as to which PHC he refers people to, he said: 'I send them either to Malshiras or Yewat. But Yewat falls in Daund taluka so most often I send people to Malshiras'.

Facilities at work site:

On an average he finds one or two cases of injury per month on his site. They keep bandages, a first aid box that contains iodine, benzoin and tablets for fevers. An injured person is given TT injections.

About other facilities at the EGS site, he said 'women don't bring their children along even though we have a shed. We have not appointed a dai because her appointment requires the presence of 5-6 children at the site'. About maternity benefits, he said: 'If a woman delivers while attending work, then she is entitled to be paid maternity leave for 15 days. Not if she delivers at home or after work hours'.

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Table: 2.1 Occupation

	Pondhe			Mavdi		
	*M	F	T	M	F	T
Agriculture	17	5	22	17	16	33
Agriculture labour	-	-	-	-	2	2
Agriculture & Agri. labour	1	-	1	-	-	-
Agriculture & Agri. labour + "Pooja"	1	-	1	-	-	-
Cattle herding	4	-	4	-	-	-
Agriculture & cattle herding	-	-	-	2	-	2
Balutedari	-	-	-	5	-	5
Agriculture + Balutedari	-	-	-	1	-	1
E.G.S. labour	1	3	4	2	13	15
Agriculture + E.G.S. labour	2	16	18	13	11	24
Private majdoor	7	-	7	3	-	3
Agriculture + private majdoori	1	-	1	1	-	1
Self employment	-	-	-	1	1	2
Agriculture + self employment	-	-	-	2	-	2
Service	2	-	2	3	1	4
Housewife	-	13	13	-	20	20
Non-worker	2	3	5	5	4	9
Total	38	40	77	55	68	123
Student	24	11	35	35	24	59
Below 5 years	5	3	8	4	5	9
N	67	54	121	94	97	191

* M : Males; F: Females; T: Total.

Table: 2.2 Distribution of Wage-earners by Sex

Pondhe Wage Earners			Mavdi Wage Earners		
Male	Female	Total	Male	Female	Total
46%	54%	35	53%	47%	59

Table: 2.3 Type of Wage Labour

	Pondhe		Mavdi	
	Wage Earners		Wage Earners	
Agricultural labour	2	(6)	2	(3)
E.G.S. labour	22	(64)	39	(66)
Private majdoori	8	(23)	4	(7)
Service	2	(6)	4	(7)
Cattle tending	1	(3)	1	(2)
Self-employment	-	-	9	(15)
Total	35	(100)	59	(100)

Note: Figures in parentheses indicate percentages.

Table: 2.4 Distribution of Wage Labour by Sex

	Pondhe		Mavdi	
	Males	Females	Males	Females
Agricultural labour	2 (13)	-	-	2 (7)
E.G.S. labour	3 (19)	19 (100)	15 (48)	14 (86)
Private Majdoori	8 (50)	-	4 (13)	-
Service	2 (13)	-	3 (10)	1 (4)
Cattle herding	1 (6)	-	1 (13)	-
Self-employment	-	-	8 (26)	1 (4)
Total	16 (100)	19 (100)	31 (100)	28 (100)

Note: Figures in parentheses indicate percentages.

Table 2.5 Educational Status of the Wage Earners

a) Pondhe

Educational Status	Agricultural labour %	EGS labour %	Private Majdoor %	Service %	Cattle herder %	Self employed %
Never attended school	-	65	29	6	6	-
1st to 4th Std.	-	100	-	-	-	-
5th to 7th Std.	-	75	17	8	-	-
8th to 10th Std.	40	20	20	20	-	-
12th Std.	-	-	-	-	-	-
Diploma	-	-	-	-	-	-

b) Mavdi

Never attended school	8	79	4	-	4	4
1st to 4th Std.	-	67	6	6	-	22
5th to 7th Std.	-	56	9	18	-	18
8th to 10th Std.	-	33	33	-	-	33
12th Std.	-	50	-	-	-	50
Diploma	-	-	-	100	-	-

Table: 2.6 Distribution of Wage earnings by Sex

Total Monthly Wage Earnings	Pondhe		Mavdi	
	Males	Females	Males	Females
Less than Rs.100/-	-	-	7 (23)	2 (7)
Rs.100/- to Rs.200/-	4 (25)	7 (37)	13 (42)	24 (85)
Rs.200/- to Rs.300/-	1 (6)	11 (58)	6 (19)	1 (4)
Rs.300/- to Rs.500/-	10 (63)	1 (5)	2 (6)	1 (4)
Rs.500/- and above	1 (6)	-	3 (10)	-
Total earners	16 (100)	19 (100)	31 (100)	28 (100)

Note: Figures in parentheses indicate percentages.

Table: 2.7 Contribution of Women's Wages to the Monthly Household Income

Contribution of Women's wages	Pondhe	Mavdi
	Households	Households
Nil	8 (40)	11 (38)
Upto 24%	1 (5)	3 (10)
25% to 49%	4 (20)	3 (10)
50% to 74%	1 (5)	8 (28)
75% to 99%	-	-
100%	6 (30)	4 (14)
Total households	20 (100)	29 (100)

Note: Figures in parentheses indicate percentages.

CHAPTER - 3

FERTILITY AND INFANT CARE

Introduction:

The chapter on fertility and infant care has been presented with a view to throw some light on two important roles that most rural women play during their life-time. They are important contributions of women to society. We have studied these aspects not with a view to monitor woma's fertility or to suggest means to control it, but because without the understanding of a woman's fertility, a true understanding of her labour power is not possible.

Fertility affects and is affected by the other facets of women's lives. Most often these interactions between production and reproduction work against the woman. We believe that a woman has little or no control over her own fertility. Whereas an unmarried woman does not have the freedom to bear a child, similarly a married woman does not have the social sanction to stay childless. It is force of circumstance, be it her job, family compulsions to bear male children, the government's policy regarding population control, that decide on women's fertility. In turn, being infertile, a pregnancy outside of marriage, bearing female children or harmful contraception vastly affect the woman's physical and mental well-being. Therefore in spite of having a negligible say about her fertility, the consequences are borne almost entirely by her.

Fertility deals with heterosexual women's bodies. To lose control over one's own body is the final submission of a human being. It is ridiculous to expect such a human to exert any influence either at a micro or macro level. The control over one's own body is an important link to attaining freedom. It is this aspect that we have tried to study in this chapter.

This chapter presents in quantitative and qualitative form, beliefs, practices, as well as management of child birth, pregnancy, infant care and contraception. We have also dealt with menstruation and taboos that exist during menstruation, pregnancy and child birth.

At the end of this chapter, we have included some typical interviews. There are three interviews (Annexures 2, 3 and 4) with traditional birth attendants (called "suins" in the local language), part of an interview with a veteran health practitioner (trained midwife) (Annexure 1). We have also attached an abridged version regarding the beliefs and practices around marriage, pregnancy and child birth, from the Maharashtra State Gazetteers, Pune District (Annexure 5 and 6).

Menstruation:

In the discussion on menstruation, women in Pondhe said that menstruation resumes around 2 years after delivery, sometimes even after 2½ years. These days they said menstruation restarts within three months after delivery. If contraception is not resorted to, conception occurs within two menstrual cycles.

At menarche, it is traditional to perform rituals similar to those of marriage. The older women complained about the younger girls: 'These days girls are very smart. They do not let it be known to family members that they have reached puberty. They learn about menstruation from their friends. Even their mother gets to know much after menarche'. The women said that they used reusable sanitary cloth pads for menstruation. Either these were

washed and dried in secluded areas, or, as the younger women preferred to do, the used pads were thrown in uninhabited areas.

During menstruation all women had to undergo segregation for four days. Domestic work such as cooking and fetching of drinking water are not allowed during this period. However, outdoor labour including agricultural and non agricultural work, washing of clothes and utensils were allowed. No religious ritual can be performed by menstruating women. Sexual cohabitation during these days is discouraged.

A girl was considered marriageable at the age of 17-18 years. Parents decide on the match. The boy and girl are allowed to 'see' each other in the presence of elders before agreeing to the match. They are not allowed to meet alone until the day of marriage. The girl's father makes all the expenses for the wedding and gives a dowry. The boy's family may or may not make jewellery for the bride. However, the mangalsutra (marriage beads worn around the neck) is given by the boy's family to the bride. After the wedding, for over one year and even when the first child is born the girl's parents send gifts (mainly clothes) to the groom's family.

They reported that amongst Dhangars, girls were married very young (there is no dowry among Dhangars). In the same week in Pondhe there were two Dhangar marriages of girls under 12 years of age. They said that the girls were sent to the husbands' house immediately. 'They get an extra hand to herd the sheep and goats'.

The average age at marriage among the Waghales in Pondhe is around 18 years. The girls showed us 'marriageable girls' among the crowd and they were around 18-20 years of age.

The average age of marriage for girls is around 16-17 years in Mavdi though a couple of marriages of younger girls have taken place in the past few years. Bigamy is very common. The common reasons cited by the men are sterility, inability to cohabit or that the wife is dark complexioned and/or ugly . The women said that sometimes, men marry an ugly girl because her parents give a large dowry. After a couple of years this wife is deserted and the mantakes a prettier bride again. In one or two cases, both wives cohabit. When asked if the first wife's consent is taken before the second marriage, they said 'only in case the first wife doesn't conceive for 10 years or so, she may agree. In all other cases, bigamy is solely a man's decision. When asked as to how one decides who is the sterile partner, they said: "They might have gone to private doctors, who knows? But a woman is more often than not considered to be incapable of conception. A man's fertility is seldom doubted. Often a man's infertility comes to light when two or three wives in a row, fail to conceive."

Pregnancy:

There were 36 ever-married women (EMW) in our sample in Pondhe (67% of the total female population in our sample), whereas in Mavdi there were 65 EMW (also 67% of the total females). In Pondhe, 53% of the EMW were in the reproductive age groups and in Mavdi, 55% were in the same. In Pondhe and Mavdi, 33% and 39% EMW

respectively have undergone tubectomy (Table: 3.1).

The average number of conceptions per woman was a little over four (4.22 in Pondhe and 3.7 in Mavdi). The highest number of conceptions per woman was found to be 11. whilst the lowest per woman was nil (zero) in both the villages. (Note: the above figures are for all ever-married women, including women with completed fertility as well as those with incomplete fertility).

Women in Pondhe said that a strict diet regimen is followed in the first four months of pregnancy. Bananas, peanuts, papaya and chicken are not allowed for fear of aborting the foetus. Knowledge of conception is through nausea, vomitting and uneasiness. Usually the mother-in-law is the first to guess. Women don't disclose their pregnancy on their own. It is for others to notice. Husbands are not confided in. Asked as to whether sexual cohabitation continues in pregnancy, they said 'Maalak (husband - 'owner') coerces'.

Women in Mavdi confirmed that there were many food taboos during pregnancy. However, if they had eaten that food unknowingly in the first month then they would continue to eat it throughout the pregnancy period. If such a food was introduced later on it caused abortions, especially in constipative persons.

Abortions and Still-births

The percentage of abortions and still-births was found to be very low in both the villages. All the reported abortions were spontaneous (2 in Pondhe and 1 in Mavdi) and were in the second trimester of pregnancy. The

respondents were not able to determine the cause of abortion.

Even on probing, the women were not able to relate the abortion to any stress, trauma or drudgery of work. The only symptom they related was abdominal ache prior to abortion and that the abortion was sudden.

We met one woman at the EGS site in Pondhe who had aborted barely a month ago, in the fourth month of pregnancy. There is no compensation on EGS for abortion at work site or due to work.

It is possible that the data on abortions is under-reported. Medical termination of pregnancy (MTP) still has stigma attached to it. Therefore women may be reluctant to undergo MTP or to report it. Pregnancies outside of marriage would naturally be aborted and would certainly not be reported to us. Speaking to health practitioners (see Annexures after Chapter 4), we learnt that a few conceptions outside of marriage had been noticed and all health practitioners had referred such women, in secrecy, to Pune for MTP.

Average abortions per EMW in Pondhe were 0.05 whereas in Mavdi, the average was 0.01.

The average still-births reported by one sample population in Pondhe was 0.08 per EMW and in Mavdi it was 0.01 per EMW.

Out of the total reported still-births (3 in Pondhe and 1 in Mavdi), three foetuses were that of males and one was that of a female.

Ante-natal Care (ANC)

Of all the EMW who had reported at least one conception, 9% in Pondhe and 17% in Mavdi had received ANC during their first pregnancy, while 16% in Pondhe and 24% in Mavdi had received ANC during their most recent pregnancy.

Almost all the women, who had received ANC reported to have been provided with iron and folic acid tablets and tetanus toxoid injections either from their Community Health Volunteers (CHV), or from the Primary Health Centre (PHC). None had received ante-natal care from private practitioners or surprisingly even from Auxillary Nurse Midwives (ANMs) in their own villages. The ANC received from ANMs was at the Out-patients Department (OPD) of the PHC.

Secondary data regarding ANC was collected through three sources for both the villages:

1. The CHVs records.
2. The MPW/ANMs records.
3. PHC record of deliveries.

All the three sources were explored, but data regarding ANC was incomplete and inconsistent. The details therefore are not presented as no analysis can be made from available information.

Age at Delivery

In Pondhe, the majority of the women (64%) reported to have delivered their first child between 21 to 25 years. Whereas in Mavdi one-third of the women had borne their

first child before they were 20 years old. (Table: 3.2). The average age at first delivery in Pondhe was 21.8 years and it was 19.2 years in Mavdi (Table: 3.1). The median and the mean age did not differ.

Age at first delivery did not show any significant correlation with landholding of the EMW's household.

In the secondary data analysed for women's age at delivery, we collected all birth records for both the villages from January 1980 to December 1986, i.e. for seven years). These records were collected from the grampanchayats, the CHVs and MPWs for cross-checking with each other. The data for Pondhe was inaccurate and inconsistent. For example, the grampanchayat records reported not a single birth in Pondhe from January 1981 to December 1985, whereas the health workers' records maintained that each of the births had been reported to the grampanchayat. Therefore, we did not analyse birth records of Pondhe village.

In Mavdi, 131 births had been recorded since January 1980 to December 1986, making for an average of 18.7 births per year.

The average age of women during their first deliveries was found to be 20.3 years, 24 years during their second delivery, 27.3 during their third delivery and 29.2 years during their fourth delivery.

When the modes were calculated the trend of the age at delivery from 1980 to 1986 was upward. For the first delivery, the modal point was 20.2 years in 1980 whereas it was 21.5 years in 1986. For the second delivery, the

modal point shifted from 23.8 years in 1980 to 24.3 years in 1986. For the third delivery, the modal point shifted from 26.8 years to 27.3 years whereas for the fourth delivery 29.8 years increased to 30.5 years (Figure 3.1) There has therefore been a small increase in the ages of women during each of their deliveries in Mavdi through the past seven years.

Childbirth:

A significant fact about childbirth in both the villages was that a majority of the deliveries were conducted at home. (Table: 3.3). Deliveries conducted at the PHC were mostly primiparous or ones with some minor complications like obstructed labour, where the woman had to be rushed to the PHC as the case could not be managed by the traditional dai in the village. (Table: 3.4).

Of the reported 131 births in Mavdi, for the past seven years (our secondary data), only one delivery had been conducted at the PHC. All other births (99.2%) had been conducted at home by relatives, elderly women of the neighbourhood or sometimes even by the delivering woman herself. No home deliveries from this sample had been conducted by ANMs.

Our qualitative data also supports the fact that there is extremely poor access to any health care for women during childbirth. Even traditional birth attendants (TBA) were often called to cut the cord or to help in the ejection of the placenta. Relatives and neighbours helped until the second stage of labour. Only when this stage was too prolonged did they think of the "suin" (TBA) or of

medical intervention. In Pondhe, the access was much worse and often women in an advanced stage of labour had to be put in a 'doli' (home-made cloth stretcher) and carried down the hills to Yewat or across seven kilometers to Malshiras PHC. (For details about childbirth please refer to Annexures 1,2,3 and 4 at the end of this chapter.)

There were two TBAs each in Pondhe and Mavdi. At a women's meeting in Mavdi, the TBA said "Younger women prefer hospital deliveries because their threshold of pain is low". In home deliveries the squatting position is strictly professed and the woman supports herself with her hands on the floor. The midwife sits in front of the delivering woman and catches the child.

In traditional deliveries the cord is cut with a blade or with a 'villi' (a scythe-like tool used in the kitchen). Pregnant women often buy a new blade a little before the due date. After the delivery, women are made to chew bitter neem leaves to stop bleeding. There is a belief that if a delivering woman sets eyes on a man wearing a coiled turban (pagota) then she gets as many painful contractions as the number of coils on the pagota.

PHC Record Of Deliveries For 1986:

1. Total deliveries conducted at the PHC in Malshiras during the year 1986 were 65, out of which none were from residents of Pondhe and four deliveries (6.2%) were from Mavdi.
2. All deliveries were conducted by ANMs.
3. Two primiparous deliveries, one aged 18 years and the other aged 20 years.

4. One woman aged 25 years had come for her second delivery and one aged 23 years had come for her third delivery.

5. The outcome of all deliveries was a live birth through a normal vaginal delivery.

Cost of Delivery:

Since the cost of delivery mainly comprised of practitioner's fees, medicines, hospitalisation and transport, our sample showed that the cost was directly related to the place of delivery and who conducted it.

All the EMW from whom information regarding their first and most recent deliveries was collected, reported no expenditure on home deliveries. A significant majority (more than 88% in all categories) constituted this group. Women have reported cost of delivery to be anything between a few rupees to over Rs.300/- per delivery. No one reported having spent more than Rs.500/- per delivery. (Table: 3.5).

Post partum Problems:

Over ninety percent of the EMW who had undergone at least one delivery reported to have had no problems during their first or most recent delivery. Bleeding, lower backache and weakness were the main post-partum problems amongst the women who reported to have had complicated delivery. One woman who suffered from typhoid during pregnancy, reported to have given birth to a female child who had hearing impairment.

The TBAs did not attend to any post-partum or neo-natal illnesses.

Outcome of Delivery:

As reported earlier, the number of stillbirths reported was low (Table 3.1). Of the total 152 conceptions in our sample in Pondhe, 149 were live births, with 99 male children (53%) and 70 female children (47%). In Mavdi, of the 241 reported conceptions, 239 were live births, with 136 male children (57%) and 103 female children (43%).

The average number of live births per EMW was 4.13 in Pondhe (male being 2.19 and females being 1.90). In Mavdi, the average number of live births per EMW was 3.67 with 2.09 male children and 1.58 female children (Table: 3.1). The median was a little lower for all categories (live births 4 in Pondhe and 3 in Mavdi).

From the secondary data (birth records of seven years of Mavdi), the outcome of 131 deliveries showed 129 live births (98.5%) and 2 still births (1.5%). One woman (a neo-Buddhist) had died during delivery in August 1983, along with her male child.

Of the 129 live births, 66 were male children (51.2%) and 63 were female children (48.8%).

Return to work aftee delivery:

Majority of the women rest for about 15 days after delivery, during which time they nurture the child at the breast. The end of the 14 days "soyar" period (a post delivery, "polluted" seclusion period for the woman and often for the household), usually marks the end of the

rest after delivery for the woman. In communities such as the nomadic "Dhangars" (cattle herders) where this taboo is not very strict, the woman returns to work almost immediately after delivery. Often she walks two hours after delivery with the baby in a basket kept on her head with the rest of the caravan for ten to fifteen kilometers and helps in pitching the tent at the new settlement.

A woman can get total rest after delivery only if she has delivered in her natal house or if there is another woman in her huaband's household to attend to all the daily household chores like sweeping, cleaning, cooking among others. (Amongst all the household chores, the men may only fetch water and at times firewood). Otherwise, rest after delivery entails not going for work outside the house but doing all the domestic work.

There was no difference in rest for the mother after the birth of a male or female child. The total rest period was extremely small and related more to social taboo than what was actually necessary to the woman.

The women mostly resume the outdoor work (fetching water, fire-wood, agricultural work, wage labour), a month after the delivery.

After delivery, buffaloes' milk, spice and sour foods are prohibited for 12 days. On the fifth day after delivery, a Satvi Pooja is performed. Five kinds of leaves are collected and 'haldi-kunku' applied. On the twelfth day the father's sister names the child. Relatives are invited for the ceremony.

Child Care

1) Breast feeding:

No woman either in the structured interview or group meeting in both villages, reported to have breast fed on the first day of delivery. Breast feeding invariably starts on the third day after delivery. No sex bias, where the offspring was concerned, was present in breast feeding practices. Even on probing, it was clear that both male and female children were exclusively breast fed for long periods of time.

A negligible percentage (3.4%) of women had bottle-fed. In all cases where substitute milk was given (18.4%), it was only because there was inadequate lactation. It was never a substitute for breast feeding but was only to supplement the breast milk.

Breast feeding often continues until the next pregnancy. Around the sixth month of the next pregnancy the first child is weaned off the breast by applying sour or bitter juices to the mother's nipples when the child demands a feed. The reason given for weaning off at this time was that "around the seventh month of pregnancy, a sticky fluid is secreted. That harms the feeding child".

Women in Pondhe, in a group meeting said that in this part of the state it is presently not very common for infants to be breast fed by other women of the household. Earlier, they said that if a mother had to go to work, the aunt or grandmother would offer her breast to the child just to soothe it. Among those who had gathered

for the meeting, only one woman confessed having breast fed the child of her female relative. That was because the mother died nine days after delivery. This incident occurred more than fifteen years ago.

2) Weaning:

Exclusive breast feeding often continues up to one year. We found very few cases where breast feeding was completely withdrawn before the child completed one year. We saw even fewer cases where supplementary weaning food was introduced before the child was almost one year of age.

The women could not articulate the gradual introduction of weaning foods (such as semi-solids to solids) but invariably said that when the child was old enough to eat (above one year of age) the child ate from the family pot. No special weaning foods were prepared. The process of weaning was not conscious, but was determined by factors such as when the mother returned to outdoor work and therefore weaning to solids was inevitable. At one year of age, milk was withdrawn and solids introduced. Milk was given only with tea or 'bhakri'.

3) Immunisation:

Of the 64 deliveries studied in Pondhe (33 first deliveries and 31 most recent deliveries of all EMWs in our sample), in 31.3% cases, no immunisation had been given to the children. There is no difference between rates for first and most recent delivery. In Mavdi out

of 102 deliveries (53 first deliveries and 49 most recent deliveries), in 11.3% cases there was no immunisation. Here too, there is no difference between first and most recent delivery (Table: 3.6). Of those who reported immunisation in Pondhe, 46.5% were immunised for small pox alone, 48.8% were immunised for small pox and other diseases whereas only 6.9% were immunised for diseases other than small pox. Since the women were only able to identify immunisations in terms of small pox, we have had to present data in that manner (Table: 3.6).

In Mavdi, of all the reported immunisation cases, 63% were for small pox alone, 4.3% were for small pox and other diseases, whereas 32.6% were immunised for diseases other than small pox (Table: 3.6). One immunisation camp had been held in Mavdi, a month prior to our survey and possibly that could account for this relatively better performance in that village.

As the women (respondents) had low articulation which immunisation, other than small pox, had been given, it was not possible to get a clear picture of the break-up of various immunisations given and consequently of the immunisation status of the children. Even on probing women were unable to tell as to which immunisation was necessary for their children and at what age and interval these had to be given.

Almost all the women reported to have got their children immunised during the immunisation camps in their village.

Death

4) Death of Children:

Though the women in our sample reported 149 live births in Pondhe and 239 live births in Mavdi, not all the children who were born were alive today. All those women who had had at least one live birth each reported a total of 42 dead children in Pondhe and 60 in Mavdi. That made for a loss of 28.2% children in Pondhe and 25.1% children in Mavdi. The distribution of male and female children who died in Pondhe was equal (21 each). In Mavdi, the number of male children who died was higher (65%) as compared to the female children (35%). The average numbers of dead children per EMW who had had at least one delivery, was 1.4 in Pondhe (0.62 male and female each) and 1.1 in Mavdi (0.71 male and 0.38 female).

The village-wise distribution of dead children by age group and sex are presented in Figures 3.2, 3.3 and 3.4. Of all dead offsrping in both the villages, 60.8% had died before they completed one year of age. Another 26.5% had died before their fifth birthday. 5.8% died before the age of fourteen. Only 7% had died after completing fourteen years of age.

Figure 3.5 depicts cause-wise distribution of deaths in both the villages.

Death Records of Mavdi:

Our secondary data analysis from Grampanchayat recordsof all deaths in Mavdi village for seven years (1980-86 end), show that 45% of all deaths occurred before

the age of 5 years. Of these deaths, 75% deaths were below the age of one year. Male deaths accounted for 46% of all deaths and 54% were female deaths. The average deaths per year worked out to be 8.

Season-wise distribution of deaths showed that 41% of all deaths occurred in the monsoons (June to September), 26% deaths occurred in winter (October to January) and 33% of deaths, occurred during the summer months (February to May).

Only 12 (22%) of the dead persons, during the seven years had received medical treatment at the time of death.

The records of Pondhe were inconsistent and therefore were not analysed.

Child Mortality and Family Size:

Tables 3.7(a) and 3.7(b) show the relationship between number of live births per woman and the loss of children through death. The analysis for Pondhe is as follows:

(1) Thirteen women out of 34 (38%) had not lost any child.

(2) There was no loss of children up to two live births.

(3) 43% of the women with three live births had no loss. 43% each had lost one child and 14% lost two children each.

(4) 33% respectively, of women with four and five live births reported no loss of children.

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(5) 66% of women with four live births lost one child each.

(6) 33% each of women with five live births lost one and two children each.

(7) 14% of women with six live births did not lose any children while 29% lost one child each.

(8) All women with eight and more live births had lost at least three children each.

The analysis for Mavdi is as follows:

(1) 28 women out of 55 (51%) had not lost any child.

(2) Women who have had up to four live births have lost only one child each. Beyond that the loss is larger.

(3) 33% of all women with five or six live births each, have lost no children. Of those who had five live births, 67% had lost two children each. Of those with six live births, 33% have lost two children each and 19% respondents had lost three and our children each.

(4) 40% of the women with seven live births have not lost any child. 20% of this group have lost one child each and 40% have lost two children each.

(5) All women with eight and more live births have lost at least two children each.

(6) 33% respondent women with eight live births have lost two, three and four children each.

(7) 25% respondents of those with nine live births have lost one, two, six and eight children each.

(8) The single woman who reported eleven live births has lost four children.

We calculated the modal point for deaths of children (0 to 4 deaths per woman) in both villages. This was with the intention of finding out as to how many live births a woman undergoes to have her desired family size. We found that with women who had not lost

any child through death, the modal point for number of live births per woman was two in Pondhe and was between two and three live births in Mavdi.

However, as the children start to die, the risk factor increases and women tend to have more live births to make up for this deficit. In both villages, for all the women who had lost two children each, the modal point for live births per woman was four. When two children died, in Pondhe women had six live births each and in Mavdi, they had between five to six live births each.

When three children per woman died, in both villages, women tended to have eight live births each. When four children died, they had close to eleven live births each.

Contraception:

None of the respondents reported to have been using spacing methods of contraception. The only form of contraception was found to be sterilisation, with the number of tubectomies for exceeding the number of vasectomies in both the villages. (Table: 3.8).

1) Spacing Methods:

We did not find any respondent or women during group meetings, who used either the diaphragm or the pill. The men did not use condoms, according to the women. The women explained that lack of privacy and disposal problems (having no garbage clearance system in the villages) were a disincentive for barrier methods.

The only data on Intra-Uterine Contraceptive Devices (IUCD) - mainly the Copper-T) was found in PHC records. We checked the Malshiras PHC records for Cu-T insertions from July 1985 to June 1986. Below we present some of the findings for Pondhe and Mavdi.

1. Total Cu-T insertions in Malshiras PHC in July 85 - June 86 = 186

Pondhe	----------	1 (0.5%)
Mavdi	----------	12 (6.5%)

2. All the IUCDs were inserted by ANMs at Malshiras PHC.
3. The average age of women in Pondhe and Mavdi at the time of Cu-T insertion was 24.7 years.
4. All the Cu-T insertions were within one year of last delivery.
5. All motivators were Multi-Purpose Workers (MPWs or ANMs.
6. Four women had no male child at the time of Cu-T insertion. Four women had no female child at Cu-T insertion.
7. Eight women had one male child, whereas seven women had one female child.
8. Whereas one women had two male children, two women had two female children at the time of Cu-T insertion.
9. No woman had inserted Cu-T before the first delivery. Whereas six women had one child each, six had two children each and one woman had three children. No woman had more than three children at the time of Cu-T insertion.
10. The average number of children per woman at the time of Cu-T acceptance was 1.6 (almost equal distribution of male and female children per woman).

2) Sterilisation:

As mentioned earlier (Table 3.8), tubectomies in both villages, far exceeded vasectomies. Of all those who had been sterilised in our sample, 84% in both villages had been tubectomised. Only 16% men in both villages had been sterilised.

The median size for the number of children per sterilised couple is three. In both villages, the median value for number of male children was two and for female children it was one. It is apparent that the most prevalent family size was two sons and one daughter. Only two couples in Pondhe, had been sterilised after two children and both of these children were male. Eighteen couples had been sterilised after three children. Of these, four couples had only male children. Fifteen couples had two sons and a daughter and only one couple who had got sterilised after three children had two daughters.

Our secondary data consisted of PHC records for sterilisation since the year 1974. We collected information regarding all sterilisations, and especially those for Pondhe and Mavdi. We present below information regarding the two villages. (See Table: 3.9).

1. Utilisation of Malshiras PHC for sterilisations is low. Of the total 542 sterilisations conducted at the Malshiras PHC since 1974 to date, 15 were performed in residents of Pondhe (2.8% of total) and

8 were performed in residents of Mavdi (1.5% of total). Our qualitative data supports this fact, wherein women in both the villages have reported an equal, if not higher, utilisation of other PHCs (Yewat in the case of Pondhe and Saswad or Jejuri in the case of Mavdi) for deliveries and, therefore sterilisatons, the latter being linked to delivery services.

2. Tubectomies far exceed vasectomies. This has come out clearly through three independent investigations, namely, our quantitative data collection, the PHC records, as well as our qualitative records. Among the 23 sterilisations performed on residents of Pondhe and Mavdi since 1974 to date at Malshiras PHC, all were tubectomies.

3. Sterilisations in the SNP unit at Malshiras (which became a PHC in April 1985) increased markedly during the two financial years corresponding to the Emergency period. The number of sterilisations have also escalated since the unit at Malshiras became a full-fledged PHC.

4. In most years, the maximum sterilisations take place close to the end of the financial year (January to March end) as compared to the rest of the year.

5. All motivations were either by ANM or MPW.

6. The average number of male children per couple at the time of sterilisation was 1.9 and that of female children 1.4. The average number of deliveries per woman at the time of sterilisation was 3.9.

7. The average age of the male at the time of wife's tubectomy was 34.9 and that of the woman herself was 29.1 years.

8. Four couples did not have a single daughter at the time of sterilisation, but there was not a single couple who did not have a son at the time of sterilisation.

9. The highest number of daughters that a single couple had at the time of sterilisation was three (three couples had three daughters each). The highest number of sons was five (one couple each had three, four and five sons respectively).

10. Of the 23 tubectomies, 14 were conducted within one month of the birth of the last child. Six tubectomies were conducted within one year of the last delivery, two within a year and a half and only one tubectomy was conducted where the last child was 3 years old.

3) Problems after Sterilisation:

Recalling their experiences about sterilisation in a group meeting in Mavdi, women said that camp sterilisations created more health problems than individual operations at health centres. Some women narrated horror stories about the Emergency period. One woman said that

she was taken away from the jowar fields in a jeep to Saswad. Another recalled how she had been literally forced into a waiting vehicle, also to Saswad. She was sterilised after midnight in very unhygienic condtions. 'There were more than fifty women like me at the hospital, all scared. They treated us like animals, literally throwing us out after the sterilisation'. While motivating them for sterilisation, their children were promised free medicines until the age of twelve years. 'They didn't even have triple vaccinations with them, leave alone medicines. They never gave any medicines or free check-ups to our children' the women recalled. A number of women from the group had been sterilised during the Emergency period. These women said that they suffer from backache even when performing household work or agricultural labour.

Asked as to why these women still opt for sterilisation, the said 'our men have to perform hard tasks every day. They can't afford to get weak. After all, what work does a woman do?'

One woman complained of amenorrhoea ever since she was sterilised in the Emergency period. Another woman complained of a prolapsed vagina. She had undergone two deliveries and a tubectomy at Malshiras PHC. Both the deliveries had been conducted in the lying down posture.

Women in Pondhe complained that sterilisation caused menstrual chaos. Two women said that their periods had become irregular since tubectomy. They would bleed for

three to four weeks at a time and then not get their menstrual periods for a month or two. Leucorrhoea also increased. These problems bothered women so much that 8 to 10 women from Mavdi have to date undergone hysterectomies within a couple of years after tubectomy. The women said 'If you have one operation, the other is inevitable. Hysterectomy is the only solution to post sterilisation problems'. All those who have undergone hysterectomies have been operated in private clinics. Each hysterectomy has cost between four to five thousand rupees .

Women in a meeting in Pondhe said that they preferred fewer children. As soon as they had the desired number of living children (2 or 3) they got tubectomised. There were a number of sterilised women in the group. The common health problem related to sterilisation was backache , they said. When asked as to whether they reported the problem to the PHC, they said 'No, because the PHC staff is mostly male'. (In truth that is not so. There are two female nurses - one NM and one ANM attending the PHC dispensary every day. Probably this statement was made because of poor knowledge about and low access to Malshiras PHC. Also the villages have only seen male workers - the CHV and occasionally the MPW who visits their village. An ANM has never visited the village as yet).

The women cited one case of severe post sterilisation problem. The woman had severe pains in the pelvic region and was taken to a private doctor in Yewat. He

performed a hysterectomy and charged Rs.2,500. This was five years ago.

On one of our visits to Pondhe, we saw a recently delivered woman being motivated for sterilisation. Everyone except she participated in the conversation. The woman in question sat with the little infant on her lap, behind a curtain, and listened to what the family members and the health worker had to say. Through this incident and through our group meetings, we want to highlight the fact that even if most sterilisations are invariably performed upon women, the latter have very little say in the matter. This alienation from their bodies could partially explain the fear and trauma that accompanies the surgery.

In our sample, 60% respondents who had undergone tubectomy in Pondhe and 41% of those in Mavdi reported some or the other problem after sterilisation. The post tubectomal sequalae ranged from menstrual chaos, aches and pains to no periods since tubectomy (Table: 3.10).

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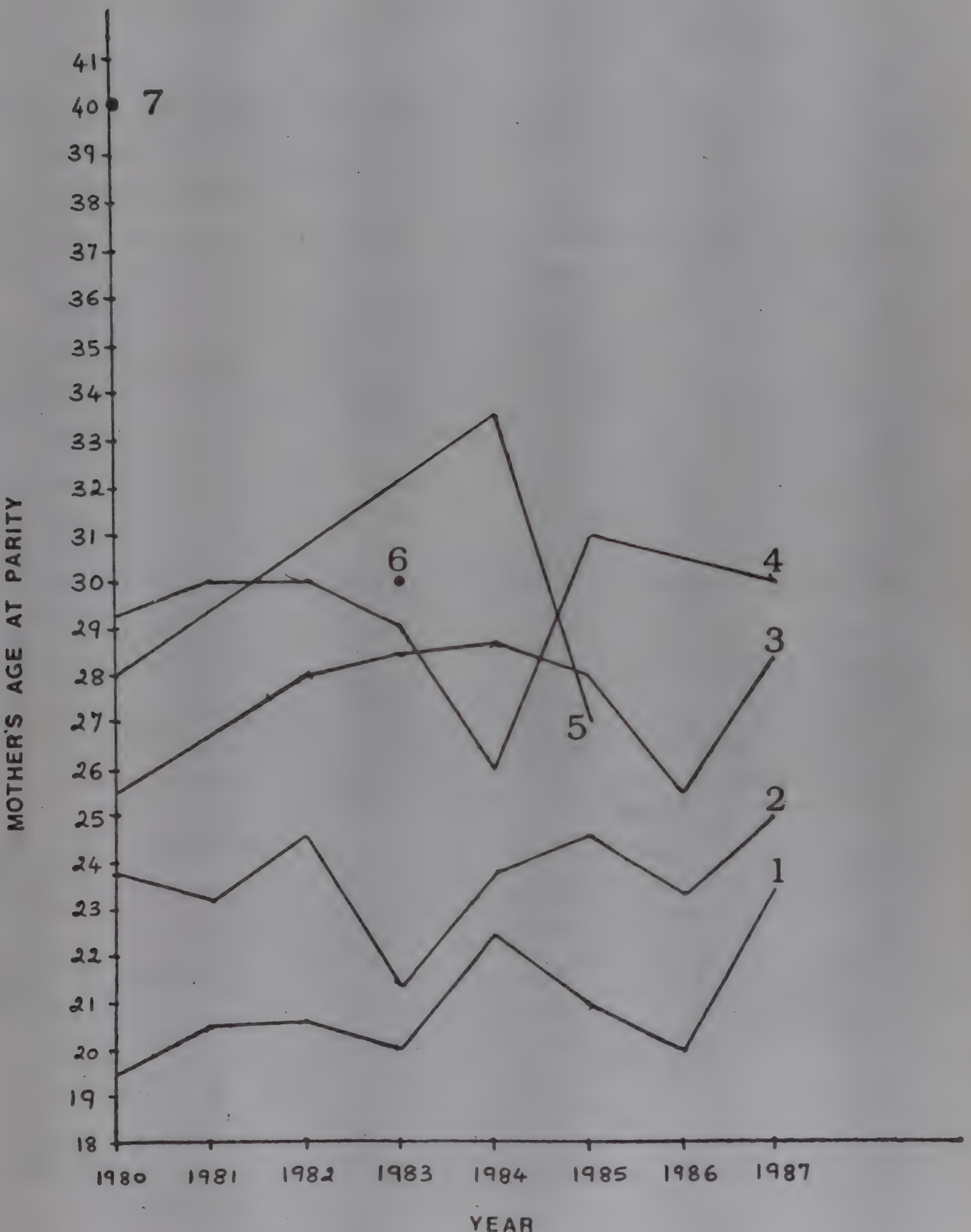
FIG 3·1 MOTHER'S AGE BY PARITY IN MAVDI
(1980 to 1987)



FIG·3·2(a) DEATH OF CHILDREN:AGE AT DEATH

PONDHE

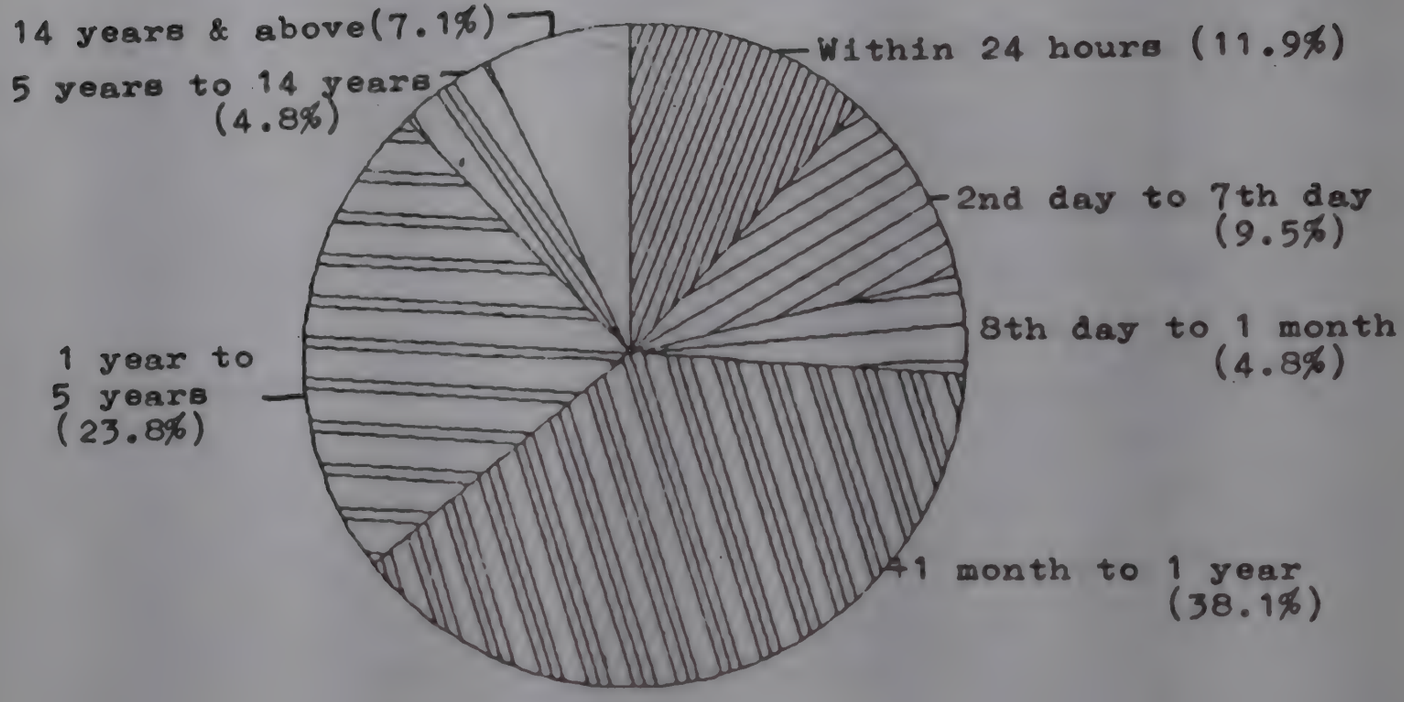

14 years & above(7.1%)
5 years to 14 years (4.8%)
Within 24 hours (11.9%)
2nd day to 7th day (9.5%)
8th day to 1 month (4.8%)
1 year to 5 years (23.8%)
1 month to 1 year (38.1%)

FIG.3·2(b) DEATH OF CHILDREN:AGE AT DEATH

MAVDI

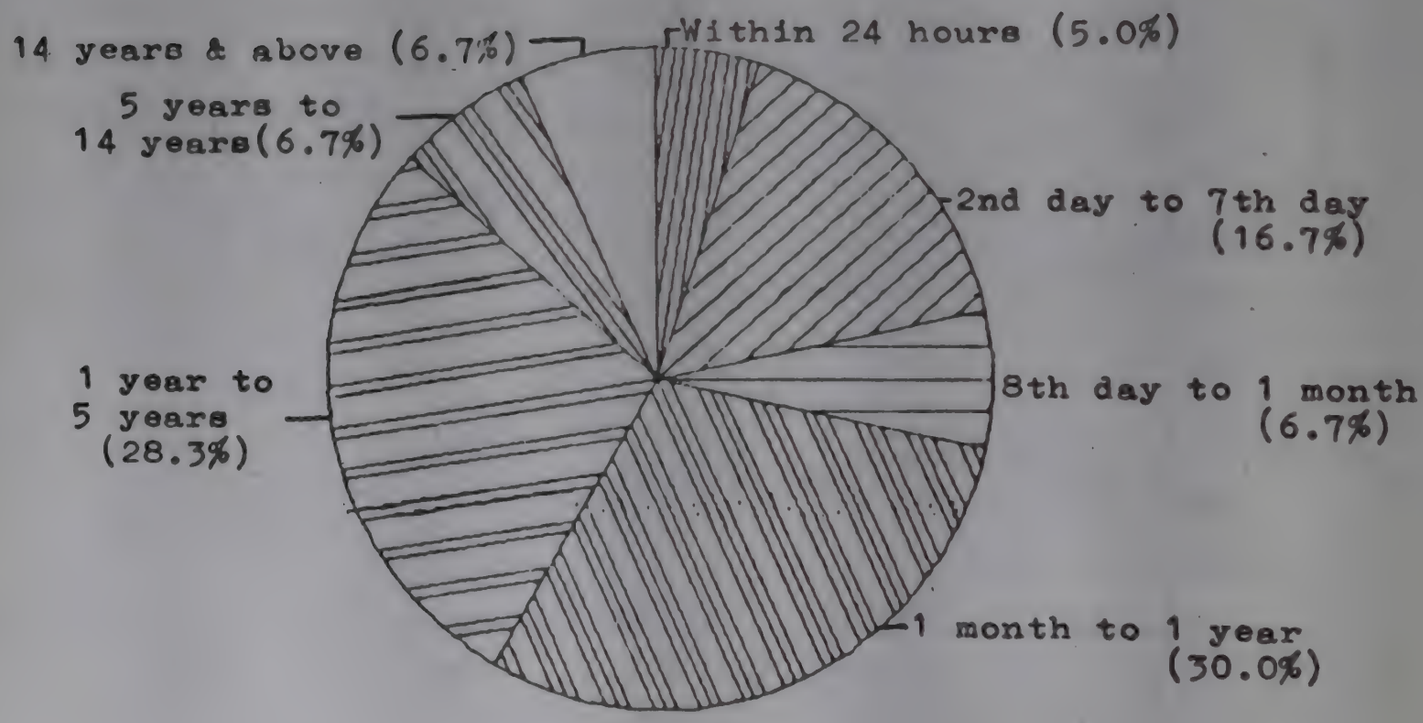
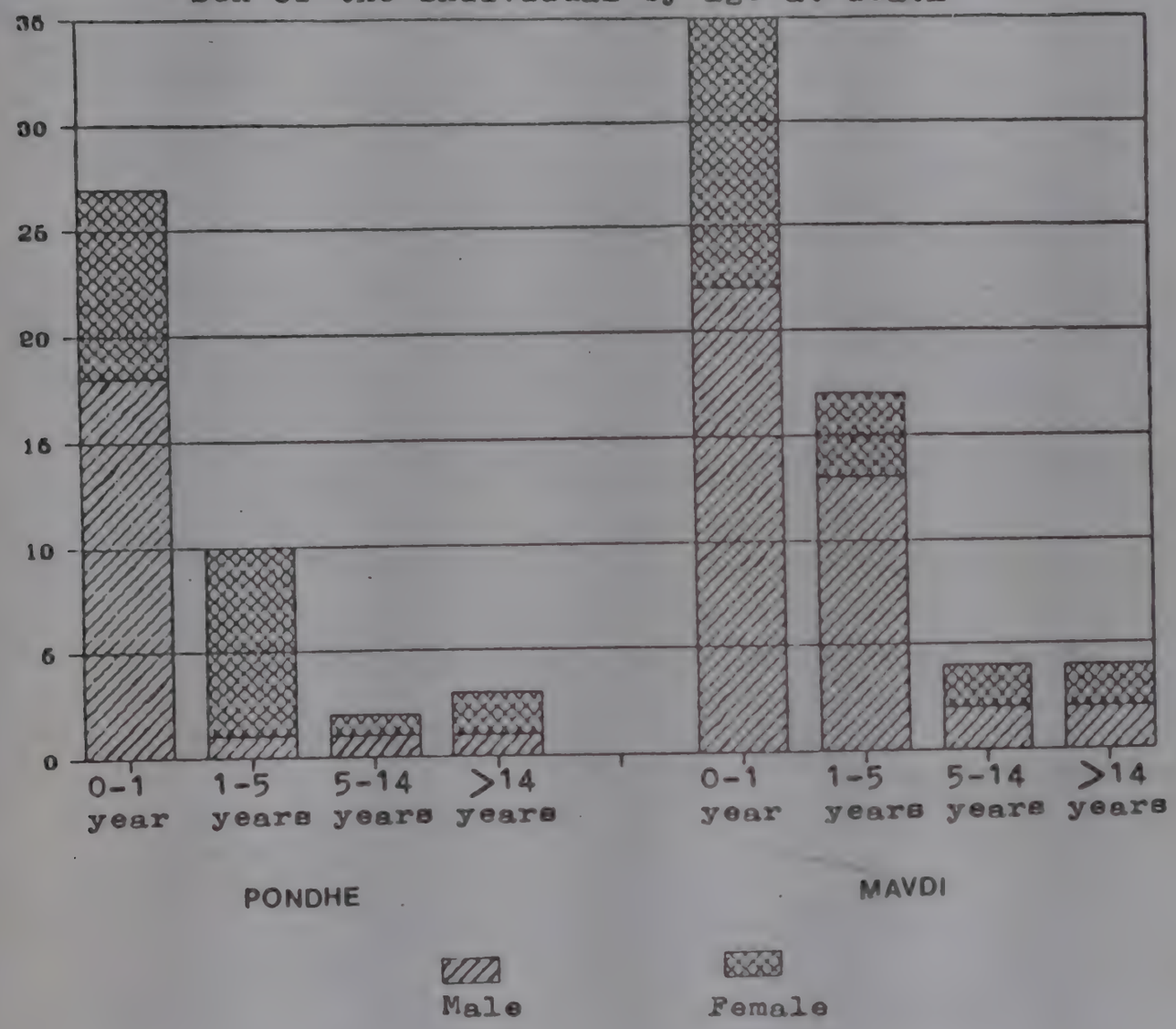

14 years & above (6.7%)
5 years to 14 years(6.7%)
Within 24 hours (5.0%)
2nd day to 7th day (16.7%)
8th day to 1 month (6.7%)
1 year to 5 years (28.3%)
1 month to 1 year (30.0%)

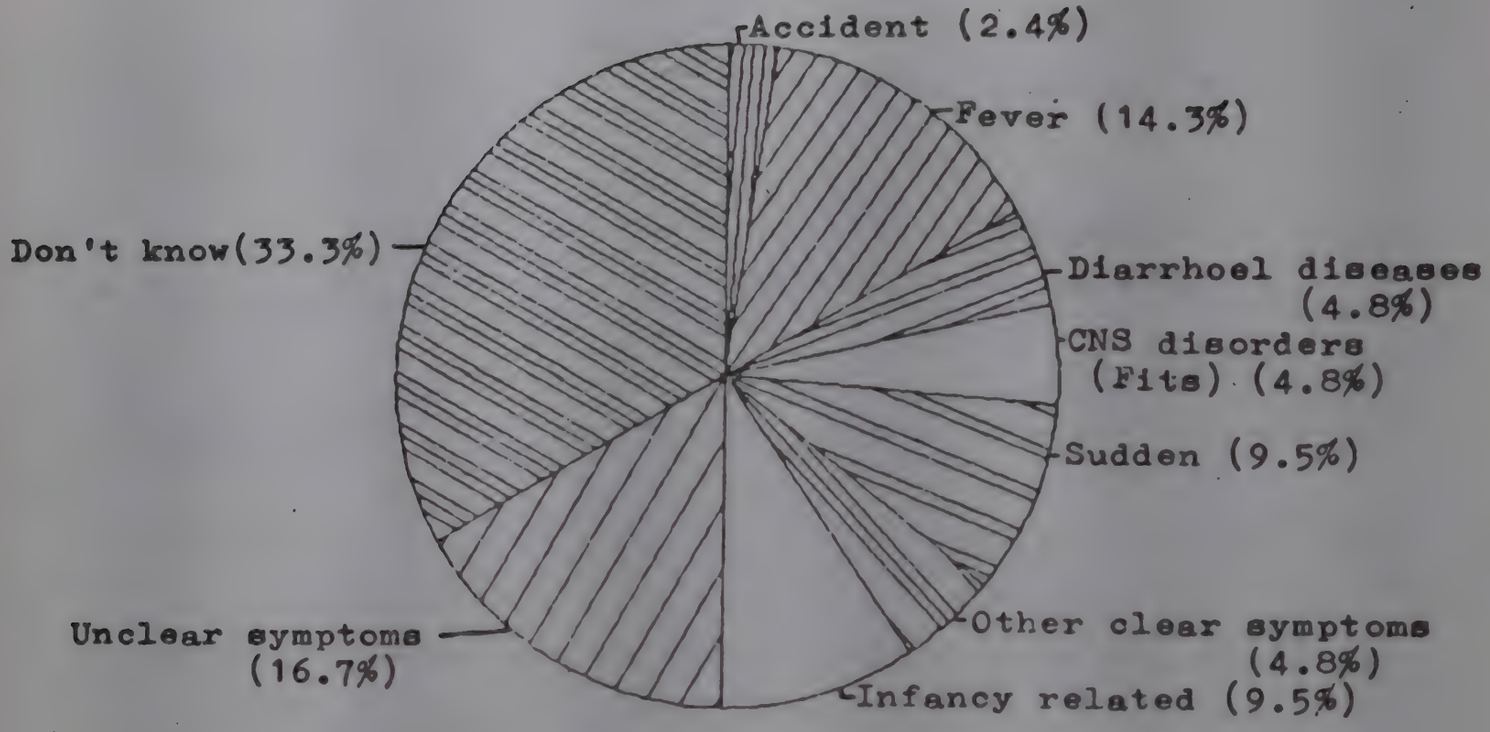
FIG.3.3 DEATH OF CHILDREN

Sex of the individual by age at death



FIG·3·4(a) DEATH OF CHILDREN:CAUSE OF DEATH

PONDHE



FIG·3·4(b) DEATH OF CHILDREN:CAUSE OF DEATH

MAVDI

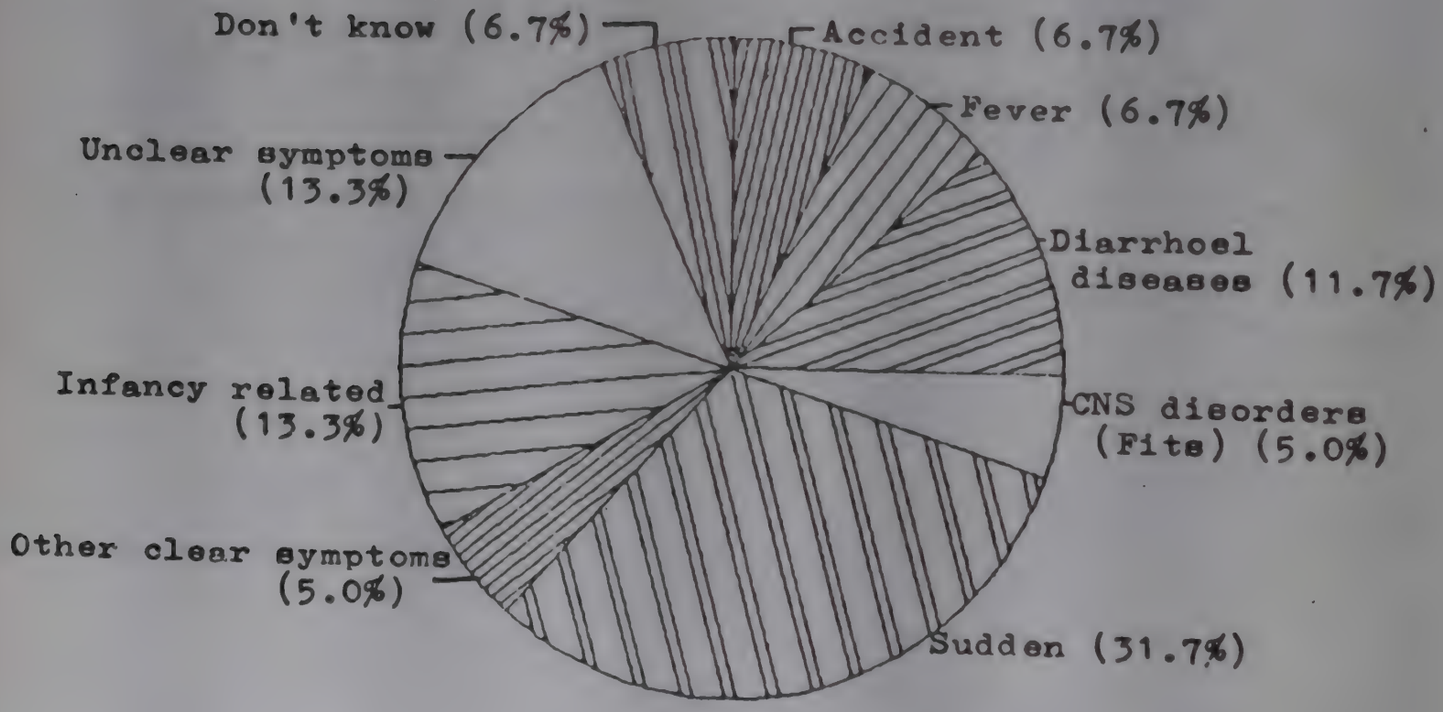
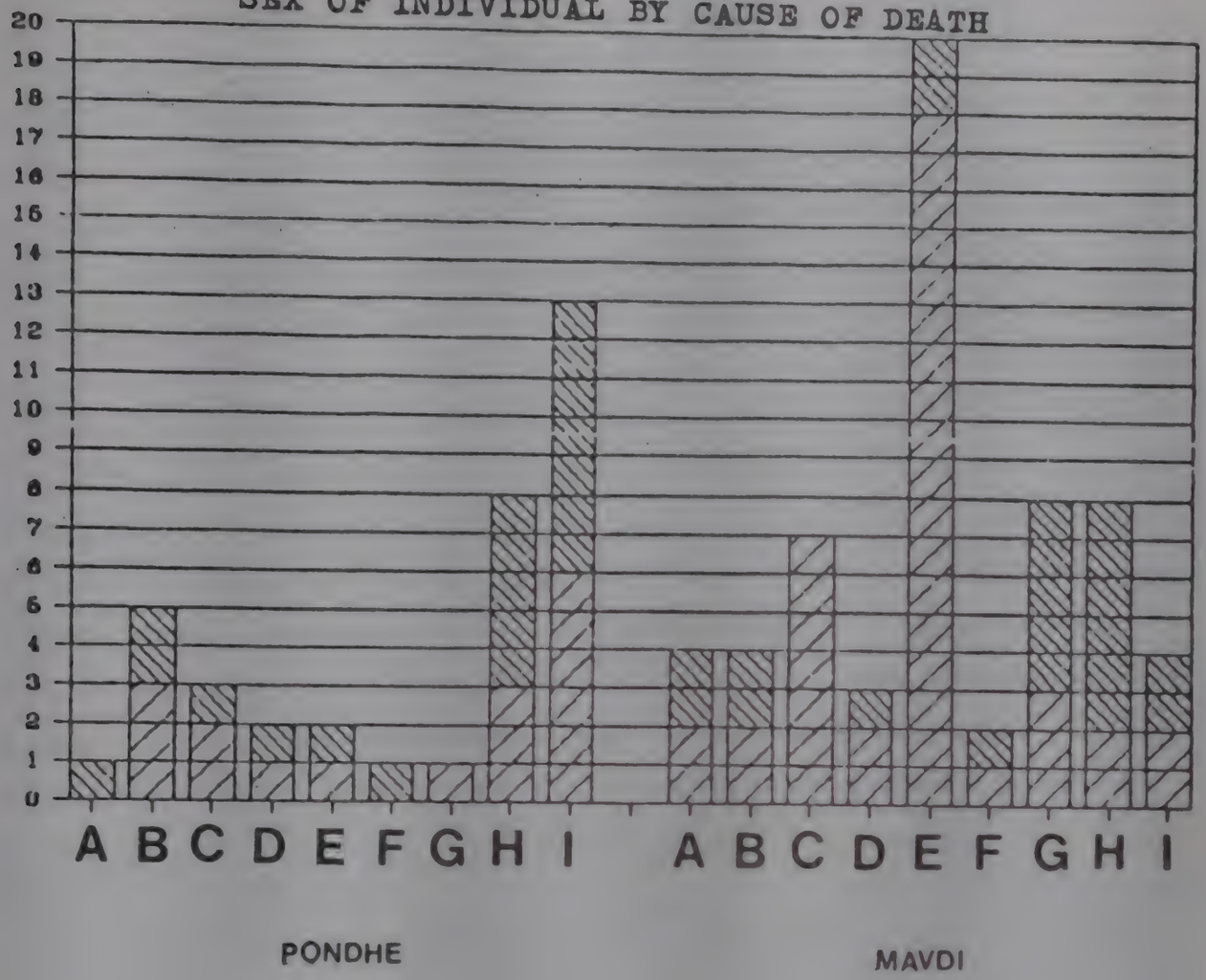


FIG.3.5 DEATH OF CHILDREN

SEX OF INDIVIDUAL BY CAUSE OF DEATH



KEY:

A	Accident
B	Fever
C	Diarrhoea Diseases
D	CNS Disorders(Fits)
E	Sudden
F	Clear symptoms
G	Infancy related
H	Unclear symptoms
I	Don't know

Annexure 1.

First part of the interview with Sr.Sudha Ganesh Apte
(A veteran health practitioner in Malshiras village)

Commenting on some of the earlier practices of childbirth, Sr. Apte says that women invariably preferred the squatting position during delivery. She feels that it is generally a good position because a woman can push better when sitting. The disadvantage of this position, she feels, is that progress of labour cannot be properly monitored. Tears are possible. Women are so used to this that they say "What is a delivery without tears?" Sr. Apte feels that home deliveries are unsafe for this reason. Conditions are unclean, rooms are dark and therefore neat incisions or stitches are not possible. Only benzoin seal is possible. Therefore though the wound heals up the tears remain and that accounts for such a high percent of gynaecological complaints in women, including prolapsed vaginae and uterii.

The threshold of pain among rural women is so high that Sr. Apte has seen delivering women stay calm even in case of post partum haemorrhage. They have walked with new-born babies within three hours after delivery, to their own villages almost ten kilometers away.

Another old belief was that any medication during pregnancy results in abortion. So women would refuse to take iron folic acid, calcium tablets or TT injections.

Even ANC was a new concept and it took a long time to convince mothers-in-law that special care and diet is required for the pregnant woman.

Speaking about some of the earlier experiences, Sr. Apte recalls that once in Mavdi, during ANC visits, she had repeatedly told the woman and the relatives that certain items, especially washed clothes to wrap the baby in, should be kept ready before delivery. But actually when she went there to conduct the delivery, no preparation had been made. The young mother pulled out a dusty bundle of dirty and smelly rags from the attic. So while the delivery was being conducted, Sr. Apte and the attendant ripped up an old but clean sari and prepared the baby's diapers and wrappers. The reason for such negligence, Sr. Apte feels, was abject poverty. "People had no money to buy soap".

During another delivery in Baramati taluka, she was called after the second stage because the placenta would not come out. When she went there, they said that the child had died and therefore they had wrapped up the child completely and had placed it in a bin. Sr. Apte first examined the child and found that it was alive. When artificial respiration, body massage and water treatment (hot and cold water dips alternately) were given, the child revived. It was a premature baby of 8 months, and had suffered from asphyxia. The woman had not been able to complete her third stage because the urinary bladder was full. Once a catheter was used and the bladder emptied out, the placenta ejected immediately.

Speaking of harmful practices, Sr. Apte related that earlier extremely hot water baths were given to neo-natals and infants. They would be wrapped up completely, including the face, with thick covers and then a fire would be placed under the baby cot. In one bizarre case, a mother left a sleeping child with the fire burning, locked the door from the outside and went to work in the field. The fire burnt part of the baby cot and the child fell into the fire. By the time the neighbours heard the child screaming and called the mother to open the door, it was badly burnt. It died later on.

Another harmful practice that still prevails is giving opium to a child so that it sleeps well. Gradually the 'dosage' is increased (one tola onwards). Besides creating dependency on opium, Sr. Apte says that most medicines have a much lesser beneficial effect on people who have been given opium in childhood. They constipate regularly and even laxatives have no effect. In one case a couple of years ago, a three-year old child was given two doses of opium by mistake (mother and grandmother each gave a dose without consulting each other) and the child was brought to the PHC. It was first declared dead, but a trained nurse from the village sent it immediately to Yewat. After an intravenous drip, it revived.

It was a difficult task earlier to explain ante-natal breast preparation to women. Panic would ensure on the third day after delivery when the baby could not suck

well enough. These days, Sr. Apte feels that younger women are much smarter because of education. They prepare well for their own delivery and don't follow the older women's maxim of "We'll see on the last day". But still younger women are made to do very hard physical labour right until the time of delivery. They have to pump or draw water from wells, lift the load on to their own head and carry these home. She feels that this practice especially is responsible for a large number of spontaneous abortions.

Women these days are also particular about fewer and healthier children. Earlier women said 'God gives, God takes' where children were concerned, but today women relatively have more access to safe deliveries than their mothers did. Younger women prefer deliveries at the PHC and opt for sterilisation after the birth of three children, especially if there are "two male children".

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Annexure 2.

Interview with Sarubai, the suin in Pondhe.
Name: Sarubai Maruti Bhadale.
Age : 55 + years
Traditional dai (suin) in Pondhe village.

Sarubai learnt midwifery by observing her mother-in-law at work. Her mother-in-law was the village midwife earlier. 'She did not allow me to participate. I merely watched. Pandurang has given me the knowledge. I have never been unsuccessful while delivering until now'.

Sarubai had received a months' training through the government health services. She went to Saswad for 8 days and then she was trained by Sr.Apte at Malshiras. She was paid Rs.300 for that period and was given a delivery kit. The kit also contains Christian proselytising material. Sarubai has never utilised any item from the kit, nor has she modified her way of delivering women after the training. She does not know how to use the enema kit. The scissors were brand new. The kit has to be dug out of a huge pile from the corner of the room. The enamel vessels were used for cooking, though Sarubai vehemently denied that.

Since the training, Sarubai has not received any monetary benefits from the PHC. 'Because I am illiterate I was not considered for the CHV's post. I don't even get the Rs.5 per woman I deliver from the government!.

Sarubai conducts 10-12 deliveries per year. Pondhe is a small village (population of 694). Sarubai cannot

maintain any birth records. She has no contact with the delivering woman prior to onset of labour. She is called when labour starts. Then Sarubai goes and examines the woman to predict the progress of labour. She does not conduct any internal examination. 'Suppose she has to go to go to hospital and the doctor notices anything wrong I would be held responsible. Also tampering with the internal organs can cause vulval swelling'.

What can she tell by examining the woman? 'If the child is alive, the lower abdomen is warm. Otherwise it is cold. If there is a breech or transverse presentation, I can tell, and then turn the foetus to facilitate labour. I don't touch the woman internally. I only feel her stomach from the outside.'

Sarubai says that it is normal here for hair to be put into the delivering woman's mouth to facilitate the second and third stages. The retching sensation causes spasmodic movements and that helps. She instructs women not to push without contractions. The squatting position is always preferred. The woman is made to lie down on her back only if ejection of the placenta is delayed.

The cord is cut with a new blade and never before the placenta is ejected.

Sometimes Sarubai is called only for the third stage of labour to cut the cord and to help the placenta come out.

Sarubai is normally given the 'haldi - kunku' and an 'oti'. Sometimes she may be given new bangles, or a blouse piece. She may also be given a small amount of jowar.

Sarubai does not have to undergo the isolation ('soyar') ritual, for 10 days after delivery. Since she gives the mother and child their first bath only, and thereafter has a bath herself in the woman's house after breaking all her bangles, she does not carry the 'uncleanliness' of the woman's household. Sarubai does not bury the placenta. Haldi - Kunku is applied to the placenta. It is then put into a vessel and buried by the family members.

Eating is encouraged during labour. 'That keeps the woman strong!', says Sarubai. When asked whether she encourages mobility, she says that a labouring woman is too weak to walk. However, if it makes a woman feel better Sarubai advises a woman to walk in the early first stage between two contractions.

If woman or child get ill after delivery, Sarubai does not intervene. She could not tell of any post partum illnesses that a mother or child may suffer from. In all the years that Sarubai has delivered women (25 years of midwifery) she has never encountered a case of sepsis, of vaginal tears during delivery or of having to give a cut (episiotomy) to facilitate childbirth.

When asked whether it is possible to determine foetal sex, she said it is not. She says it is fraudulent

to say that sex of a foetus is predictable. However, she says, that there is a belief that if itis a male foetus, then the stomach protrudes more forwards and if it is a female foetus then the stomach is broader and bulges more on the sides. She was only half serious when she said this.

The cord is cut immediately after the completion of the third stage. The child's mouth is cleaned with a piece of cloth and then it is fed sugared water with a piece of cotton. On the second day, oil is applied to the baby's scalp, ears and navel.

Breast feeding is started on the third day. No water is thereafter given to the child. Exclusive breast feeding continues thenceforth. When asked as to how she copes with cases of failure to breast feed she asked, very surprised 'Why will God ever give a child to a woman and then not give milk for it's survival?'.

For 5 days after the delivery, the mother is given rice and ghee with sugar to eat. She is given warm water to drink. No salt is added to her food during these days. Of she is bleeding too much she is given jaggery to eat. Only after the 'Pachavi' pooja, a woman can eat salt. She is given spices after 12 days of delivery.

Sarubai believes (as most of the women in her village also believe) that if a pregnant woman eats well, the child in her womb is malnourished. Only if one starves a pregnant woman can one get a healthy and large baby. If

a weak child is born, the women present at the delivery make derogatory remarks about the mother (e.g., 'She ate at the cost of the child' or that 'the child suffers for her greed').

Neonates are also very vulnerable to 'evil eyes' according to Sarubai. If a newborn child 'changes colour' from blue to yellow to green, sometimes resulting in death, Sarubai is sure that it is evil eye. There are Devrishis in the village who can tell if it is an evil eye or if it is the curse of Kalubai'.

Malnourishment or 'mooddoos' occurs if the pregnant woman walks over a puddle of water with which a corpse has been bathed. If the 'Ran satvi' possesses a pregnant woman in the woods, then the child is forever thin and cranky.

Sarubai herself has never had any conception. She lives alone with her husband and baby-sits many children from her neighbourhood voluntarily, so that their mothers can go out and earn wages.

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Annexure 3.

Interview with Gajarabai - Suin in Pondhe.

Gajarabai has been a midwife now for around twenty-five years. She learnt the art from her aunt-in-law. She would accompany the older woman to deliveries and the older woman taught her saying that "I'll die soon, so learn from me".

All of Gajarabai's six deliveries were conducted by herself. When each child was born Gajarabai measured ei ht fingers' width of cordlength, put her foot down on the umbilicus and cut the cord with a blade. She does not like dispensaries and even though she has no immediate in-law (mother-in-law) staying with her, she refused to go to any hospital for her deliveries.

Gujarabai believes that her art is ordained by God. Therefore she does not charge any money for conducting deliveries, though she lives in a tattered hut in the Maharwada of Pondhe village. 'God helps a delivering woman. If the skill does not belong to me, how can I charge fees? Can any human being help in obstructed labour? It is God who helps. Then how can I take the credit?' she asks.

Her children (four sons and one daughter) are now grown up. The elder son is married, while the younger child, a daughter, studies in the seventh standard in school. One daughter died at the age of three years with fever - probably of food poisoning. Medical care was not available, and neither did Gajarabai have any money to buy any medicines. The child died within a day.

Gajarabai's procedure of conducting deliveries is not much different than that of Sarubai the other.suin

in Pondhe. However, Gajarabai gives an oil massage on the abdomen to facilitate labour. She also gives an internal examination to the woman with a piece of cloth to check how far the foetus has progressed. She, like Sarubai cuts the cord with a blade (old or new), only after the placenta is ejected. She also gives baths and massages to infants up to the age of six months.

Gajarabai, though a dalit herself, conducts even non dalit deliveries. When asked as to how she is called for deliveries of the upper caste women, she says 'It is a moment of need for everybody'. Gujarabai is very popular with families of dalit castes. However Sarubai is also called into the Maharwada for deliveries. When asked as to why, Gajarabai says 'There are some people with whom I may not have cordial relations; they call the other suin'.

Gajarabai is conscious of Sarubai's social superiority as well as of Sarubai's age. At any delivery where both may be called, Gajarabai says that she always gives Sarubai more importance and behaves with humility even if she 'knows better'.

How doex she cope with unexpected emergencies? She says that if a woman is in obstructed labour, she refers her to a medical practitioner. Often, she says women are made to push much before the second stage. Not only does that cause harm but it also exhausts the woman so much that she cannot actively participate later on. Gajarabai vividly remembers one emergency that she coped with. Eight years ago, a delivering woman presented with a prolapsed vagina. Gajarabai broke her own bangles and with her bare thumbs manipulated the child outside. Once the child was safely delivered, she pushed back the internal organs with her fist. The woman, Gagarabai says is hale and hearty today. Luckily, she says, she has not had such a problem more than once.

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Annexure 4.

Interview with Smt. Babai Shankar Vaikar, the suin in Mavdi. (Age around 60 years)

Babai is not a trained dai. Her husband's aunt was a suin and that's how she learnt to deliver. Another practical experience was through conducting her own deliveries.

She goes to a woman's house only when called. She doesn't examine the woman internally. She cuts the cord (after third stage) with a blade and helps in catching the child skillfully. If the third stage is delayed she pushes with her fist on the women's abdomen and puts the woman's hair into the woman's mouth. The retching sensation helps in ejection of the placenta. She strictly prefers the squatting position.

Babai gives mother and child a bath immediately after delivery. If they so request, she also continues giving a bath to both mother and child for 12 days.

She can predict time of labour accurately (some women who were present during this interview strongly seconded this statement) and says that if the lower abdomen is cold, the child is dead inside. She does not believe in foetal sex determination. She also does not give much importance to "evil eyes". She says that in any delivery, it is of primary importance that the women

is saved, even if the child is stillborn or dies during birth.

Babai and the other women were discussing beliefs regarding pregnancy and childbirth. Babai and the older women agreed that a child was born underweight if the woman ate well during pregnancy. "The child rots in excess food and therefore development is hampered" they said. They also asserted that if a mother-in-law fed the pregnant woman with stale food the placenta was very large. At this point some younger women intervened and contradicted these beliefs with their own experiences. There was an animated debate and plenty of laughter, after which the older women said "It is a matter of belief. These feelings exist more in the mind. Who knows what is the real reason for happenings such as underweight babies? We have always been told these explanations but now the young educated girls don't accept these reasons".

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Annexure 5.

Abridged from the Maharashtra State Gazetteers - Pune District

Marriage:

As soon as a girl attains a marriageable age, her parents anxiously look out for a suitable match for her. When they come across such a boy, the confirm if the boy's marriage is contemplated and send their daughter's horoscope to the head of the boy's family through the family priest or a common friend. They boy's father in turn takes the girl's horoscope to an astrologer and consults him on the matching of the horoscope with his son's.

As soon as the girl is approved of, the heads of both families draw up an agreement regarding the money to be given by the girl's father to the boy and the ornaments and clothes to be given by the boy's father to the girl. An auspicious day is fixed as the wedding day and both the families busy themselves with the marriage preparations.

The marriage ceremony is not complete until the giving away of the bride (kanyadaan) on the part of the bride's parents, followed by that of accepting of the bride (kanyapaanigraha) on the part of the bridegroom.

Before settling upon a match, it has to be ascertained that the kuli (sept) and devak (crests or marriage guardians) of the boy's and the girl's father are not the same, are suitably different and by usage not interdictory.

Sameness of devak by the mother's side and even of surnames do not bar marriage. As regards cross-cousin unions, except the brother's daughter and sister's son type, which is tolerated and even preferred amongst many, other types are generally disallowed. Marriage with a wife's sister is allowed and a man may marry his brother's wife's sister.

Among the poor and the backward communities it is customary for the boy's father or a near relation to initiate marriage negotiations, but in the well-to-do families such arbitrations usually commence from the girl's family.

There are no social restrictions on widow remarriage among many communities, though such a marriage is considered disreputable. As a rule, only widowers marry widows and their children do not get a share of property as those of first marriages.

A widow remarriage is called 'pat' or 'gandharva' and is generally performed at night in a secluded open space outside the village. It is attended by none of the relations of the bride or of the bridegroom. A priest conducts the marriage service. The newly married pair is prohibited from entering the village that night and so they pass the night in a 'mal' (open ground) or a field hut. It is inauspicious to see their faces the next morning until they have bathed and visited the temple of the local village deity. There are no such taboos when a widower remarries, unless he marries a widowed woman.

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Annexure 6.

Abridged from the Maharashtra State Gazetteers - Pune district

Pregnancy and Childbirth:

The prospect of childbirth is a much awaited event in the family. The woman is treated with great care and tenderness. As the belief goes, in the fourth month, the foetus develops a heart and starts desiring things, which is reflected in the longings the woman begins to have and she is called a "dohalkarin". Since these longings are believed to foreshadow and influence the characteristics and sex of the child, they are always promptly satisfied by the family members.

In case of the first pregnancy, the woman is considered particularly open to attacks of evil spirits and has to comply to a lot of restrictions on her physical movements and diet. It is also believed that the husband's doings during his wife's pregnancy affect his wife and the unborn child; hence he has to avoid certain acts.

The woman as a rule goes to her natal home for her first confinement. Efforts are made to keep her cheerful and happy. At the onset of labour, she is taken to an inner room which has been swept clean and kept warm and is dimly lit. A midwife who is generally engaged beforehand is sent for. Experienced elderly women of the family also assist the midwife. Only women are allowed to be present during the childbirth.

After delivery, the young mother is washed and laid on the cot. The midwife ties the umbilical cord with a cotton thread, a few inches away from the navel, and severs it with a knife. She also rubs the mother and the child with turmeric, oil and gram flour and bathes them with hot water. The child is then dressed in swaddling clothes and laid besides its mother. The midwife puts the placenta in an earthen pot with a pice (small change of a rupee) and betelnut and buries it in the compound.

It is believed that the first ten days after the delivery are full of danger to the newborn as well as the mother and a number of precautionary measures are followed to guard them against evil influences. Soothing verses are recited every evening and ashes are applied on the brows of the mother and the newborn. A light is kept burning day and night in the room, and the mother is never left alone. The mother is usually given a special meal for the first two days and may revert to the normal one on the third day.

The fifth (pancvi) and the sixth (sasthi) nights are considered to be critical for the newborn. A lot of religious rites are performed and women stay awake the whole night, playing games and singing religious songs.

As a consequence of the childbirth, the mother is considered to be unclean for ten days and no one except the midwife touches her. The family also observesceremonial impurity (suher or soyar) for that period. On

the tenth day, the mother and the child are given purificatory bath. The whole house is cleaned, the walls and the ground is smeared with a mixture containing cowdung. The bathing place (room) is also washed clean and turmeric, vermillion (red powder used to mark women's brows), flowers and a lighted lamp, are laid near it. The midwife is presented with a set of new clothes and money.

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Chapter - 3

Tables

Table 3.1 Women's Fertility (Consolidated Findings)

	Pondhe	Mavdi
Total females	54	97
Total ever married women (EMW)	36	65
EMW in reproductive age	10	21
Total conceptions	152	241
Total abortions	2	1
Total still births	3	1
Total live births	149	239
males	79	136
females	70	103
Total live children	107	179
males	59	97
females	48	82
Total dead children	42	60
males	21	39
females	21	21
Average conceptions per EMW	4.22	3.70
Average abortions per EMW	0.05	0.01
Average still births per EMW	0.08	0.01
Average live births per EMW	4.13	3.67
males	2.19	2.09
females	1.94	1.58
Average live children per EMW	2.97	2.75
males	1.63	1.49
females	1.33	1.26
Average dead children per EMW	1.4	1.1
males	0.62	0.71
females	0.62	0.38
Average age at first delivery	21.8	19.2

Table 3.2 : Age at First Delivery

Age	Pondhe	Mavdi
	EMW	EMW
Below 20 years	10 (29)	43 (80)
21 years to 25 years	23 (68)	10 (18)
26 years to 30 years	-	-
31 years to 35 years	1 (3)	1 (2)
Total EMWs	34(100)	54(100)
N.A.(not delivered)	2	11

Table 3.3 : Place of Delivery

Place of Delivery	Pondhe		Mavdi	
	First delivery	Most recent delivery	First delivery	Most recent delivery
	EMW	EMW	EMW	EMW
In the House	31 (91)	29 (94)	45 (83)	45 (90)
P.H.C.	3 (9)	2 (6)	8 (15)	3 (6)
Private Hospital	-	-	1 (2)	2 (4)
Total EMWs	34(100)	31(100)	54(100)	50(100)
N.A.(not delivered)	2	5	11	15

Table 3.4 : Delivery Conducted By

Delivery Conducted By.	Pondhe		Mavdi	
	First delivery	Most recent delivery	First delivery	Most recent delivery
	EMW	EMW	EMW	EMW
Self	4 (12)	4 (13)	-	1 (2)
Relatives	22 (64)	19 (61)	37 (68)	38 (76)
TBA	4 (12)	5 (16)	8 (15)	5 (10)
ANM	4 (12)	3 (10)	8 (15)	3 (6)
Doctor	-	-	1 (2)	3 (6)
Total EMWs	34(100)	31(100)	54(100)	50(100)
N.A.(not delivered)	2	5	11	15

Table: 3.5 : Cost of Delivery

Cost of Delivery	Pondhe Deliveries	Mavdi Deliveries
No cost	60 (92)	92 (88)
Upto Rs.50/-	1 (1.5)	4 (4)
Rs.51/- to Rs.100/-	1(1.5)	- -
Rs.101/- to Rs.150/-	1(1.5)	1(0.96)
Rs.151/- to Rs.200/-	1(1.5)	5 (5)
Rs.201/- to Rs.300/-	-	1(0.96)
Rs.301/- and above	1(1.5)	1(0.96)
Total deliveries *	65(100)	104(100)
N.A.(no deliveries)	7	26

* Total deliveries include first and most recent deliveries of the EMW in the sample population.
(Note: Figures in parentheses indicate percentages.)

Table: 3.6 : Immunisation

Immunisation	Pondhe		Mavdi	
	First delivery	Most recent delivery	First delivery	Most recent delivery
	EMW	EMW	EMW	EMW
No immunisation	10 (30)	10 (32)	6 (11)	4 (8)
Small pox only	11 (34)	9 (29)	29 (55)	29(59)
Small pox & others	10 (30)	11 (36)	2 (4)	2 (4)
Any other	2 (6)	1 (3)	16 (30)	14(29)
Total	33(100)	31(100)	53(100)	49(100)
N.A.(no deliveries)	3	5	12	16

(Note: Figures in parentheses indicate percentages)

Table: 3.7

a) Pondhe

Live Births	Number of Dead Children						
	Nil	1	2	3	4	6	Total
1 live birth	3(100)	-	-	-	-	-	3(100)
2 live births	3(100)	-	-	-	-	-	3(100)
3 live births	3 (43)	3(43)	1(14)	-	-	-	7(100)
4 live births	2 (33)	4(67)	-	-	-	-	6(100)
5 live births	1 (33)	1(33)	1(33)	-	-	-	3(100)
6 live births	1 (14)	2(29)	3(43)	1(14)	-	-	7(100)
8 live births	-	-	-	1(50)	-	1(50)	2(100)
11 live births	-	-	-	-	1(50)	1(50)	2(100)

Total EMW with at least one live birth = 33.

EMW with no conception = 2.

EMW with one still birth = 1.

(Note: Figures in parentheses indicate percentages).

Table : 3.7

b) Mavdi

	Number of Dead Children							
	Nil	1	2	3	4	6	8	Total
1 live birth	4(80)	1(20)	-	-	-	-	-	5(100)
2 live births	8(67)	4(33)	-	-	-	-	-	12(100)
3 live births	9(82)	2(18)	-	-	-	-	-	11(100)
4 live births	2(40)	3(60)	-	-	-	-	-	5(100)
5 live births	1(33)	-	2(67)	-	-	-	-	3(100)
6 live births	2(33)	-	2(33)	1(17)	1(17)	-	-	6(100)
7 live births	2(40)	1(20)	2(40)	-	-	-	-	5(100)
8 live births	-	-	1(33)	1(33)	1(33)	-	-	3(100)
9 live births	-	1(25)	1(25)	-	-	1(25)	1(25)	4(100)
11 live births	-	-	-	-	1(100)	-	-	1(100)

Total EMWs with at least one live birth = 55

Total EMWs with no conception = 10.

(Note: Figures in parentheses indicate percentages).

Table: 3.8 : Contraception

Contraception	Pondhe	Mavdi
No contraceptive	24 (66)	40 (62)
Vasectomy	2 (6)	4 (6)
Tubectomy	10 (28)	21 (32)
Total EMW	36(100)	65(100)

Table: 3.9 : P.H.C. Record of Sterilisation

	Item	Value
1.	Total sterilisations recorded	542
2.	" " (Pondhe (All tubectomies))	15 (2.8%)
3.	" " (Mawdi (All tubectomies))	8 (1.5%)
4.	Average age of male	34.9 yrs.
5.	" " of female	29.1 yrs.
6.	Average male children/couple	1.9
7.	" female " "	1.4
8.	Average deliveries/woman	3.9
9.	Tubectomies within 1 month of last delivery	14(60.9%)
10.	Tubectomies within 1 yr. of last delivery	6(26.1%)
11.	Tubectomies within 1½ yr. of last delivery	2 (8.7%)
12.	Tubectomies within 3 yrs. of last delivery	1 (4.4%)
13.	Couples having no daughters	4(17.4%)
14.	" " no sons	0
15.	" " more than 3 daughters	0
16.	" " " " 3 sons	2 (8.7%)
17.	" " 2 daughters	8(34.8%)
18.	" " 2 sons	12(52.2%)

Table: 3.10 : Problems due to tubectomy

Problems	Pondhe	Mavdi
Stomachache & Weakness	-	1 (5)
Irregular menstrual periods and heavy bleeding during periods	1 (10)	1 (5)
Bodyache	1 (10)	-
Stomachache	2 (20)	3 (14)
No menstrual periods after tubectomy	1 (10)	-
Bodyache & Backache	1 (10)	2 (9)
Bleeding, Backache and Watering of the eyes.	-	1 (5)
Backache and Weakness	-	1 (5)
No problems	4 (40)	12 (57)
Total tubectomy cases	10(100)	21(100)

(Note: Figures in parentheses indicate percentages)

CHAPTER - 4

ILLNESS AND ACCESS TO HEALTH CARE

Pondhe and Mavdi are covered under the project area of the Primary Health Centre at Malshiras. Both the villages do not have a sub-centre. There is a Community Health Volunteer, one each, in Pondhe and Mavdi.

Although most of the households in both the villages were aware of the existence of the Primary Health Centre at Malshiras, (table 4.1), only one household from Pondhe and four households from Mavdi had actually visited the P.H.C. during the past three months.

As far as awareness about the health workers (M.H.W./M.P.W., A.N.M. & C.H.V.) was concerned, none of the households in either of the villages had correct knowledge about the functions of the health workers (Table 4.2). Correct knowledge implied knowledge about all the functions of the village health workers. It is possible that the health workers do not perform all the functions, that we know they are supposed to perform, and therefore the people were not able to enumerate all the details.

Most of the households in Pondhe had no knowledge about the Multipurpose Worker (M.P.W.). A few households who were aware about the M.P.W., reported that they had seen the M.P.W. go to the C.H.V.'s house during his visits in the village. In Mavdi, 65% of the households

were aware of the nature of the M.P.W.'s functions which they enumerated as collecting blood samples and dispensing medicines.

All the households in both the villages reported that no "nursebai" had ever visited their village, in the recent past, and hence had no knowledge about the A.N.M. In contrast to this, all the households in both the villages were aware of the C.H.V. in their village, whose major function, they said was, of dispensing medicines for minor ailments.

Actual Utilisation:

While the actual utilisation of the M.P.W.'s services was very low in both the villages, it is important to acknowledge that children from six households in Mavdi had been immunized by the M.P.W. during the course of the past three months. (Table 4.3) The utilisation of the services rendered by the C.H.V. was higher compared to that of the M.P.W. in both the villages. Majority of the households reported to have taken medicines for minor ailments from their C.H.V.

Treatment Sought For Minor And Major Ailments And Gynaecological Complaints

Data regarding the hypothetical query about the choice of place of medical treatment for minor and major ailments and gynaecological complaints depicted that for minor ailments the respondents from Mavdi preferred to go to the P.H.C. at Jejuri (12 kms from Mavdi), while

the preference in Pondhe was equally divided between the P.H.C. at Malshiras and Private Practitioner at Yewat (5 kms. from Pondhe)(Table 4.4). Both Jejuri and Yewat villages are market places, hence it is possible that people find it convenient to seek treatment, even for minor ailments, during their weekly visits to these villages.

Choice of the place of treatment for major ailments, which demand urgent attention, was clearly that of private practitioners, in both the villages (Table 4.4)

As far as gynaecological complaints were concerned, the respondents from Pondhe preferred going to the private practitioner at Yewat, whilst at Mavdi, the respondents' choice seemed to be equally divided between private practitioners and the P.H.C. at Jejuri.(Table4.4)

The preference for treatment of major and minor ailments as well as gynaecological complaints is directly related to the status of the households (Table 4.5 a,b &c) in both the villages. The upward mobility of the status of the household results in the change of choice of treatment from the P.H.C. to the private practitioner.

In a group meeting in Mavdi, we were pleasantly surprised to find the sensitive handling of leprosy by the public health services. Two of the women present (the Devrishi was one of them) showed patches on the face and arms respectively. They had taken treatment 'from the govt. hospital in Saswad' because the patches were anaesthetic. The treatment was over and they said they had recovered. They could not articulate as to

which disease they had had because they had not been told the name. They were merely told 'it is a stubborn skin infection which will heal with long medical care'. The other women too did not regard this infection with any special interest or contempt. Neither of the women was disfigured.

Illness Episodes During The Past One Month:

The incidence of illness amongst the sample population, as reported by the respondents, was quite low. Only 12 percent of the respondents, each, in Mavdi and Pondhe reported to have been ill during the past one month, with illnesses ranging from cough and cold to kidney stone. (Table 4.6).

Neither of the authors were clinically qualified to conduct a medical check up of the population and we are aware that this would leave large gaps in our study of morbidity. We have mainly collected symptoms that were presented to us. Being aware that even innocous symptoms could be the result of a grave illness (for example, cough could be related to tuberculosis), we have tried to cover as much information on illness in our group meetings with women. We have tried to present as best as we can the link between work, maternity and health in our qualitative analysis. It is interesting to note that even in the P.H.C. case papers, the symptom and not the illness is presented in the section on diagnosis.

Age wise distribution of illness during the past one month indicates no morbidity amongst the infants in both the villages. At least one case each of the childhood diseases like mumps, measles, diarrhoea, scabies and an eye-infection was evident amongst the children in the sample population. Symptomatic complaints like general weakness, burning sensations in the stomach, blood in stools, headaches were found to be health complaints amongst the adult population. Chronic ailments like asthma, arthritis were reported amongst the aged population. (Table 4.7 (a) & (b)).

Sex-wise distribution of illness during the past one month indicates a marginally higher morbidity amongst the female population as compared to the males. Amongst the total sample population, 13(8%) male respondents and 23(15%) of the female respondents reported to have some health problems during the past one month. Main health complaints amongst the females were chronic, like headaches, blood in stools, arthritis, asthma and weakness. Our qualitative data also corroborates the above findings, wherein, women during the group meetings said that headaches and weakness were their common health complaints, more so in the case of E.G.S. wage labourers. (Table 4.8).

Utilisation of Health Services For Illness During The Past One Month.

Village	All P.H.C.s*	Pvt. practitioner	C.H.Vs	No treatment taken
Pondhe	1 (7)	10(67)	2(13)	2(13)
Mavdi	8(38)	10(48)	-	3(14)

* PHCs include those at Malshiras, Saswad, Jejuri and Yewat.

Total government health services utilization :

Pondhe - 20.00%

Mavdi - 38.09%

Type of Treatment :

The type of treatment for various illnesses showed interesting details. Injections were reported to have been given for ailments like cough and cold, stomach ache, and diarrhoea. Medical treatment was not sought for a case each of fracture, menstrual disorder, asthma & blood in stools. Reporting of the illness, by the respondents was mostly symptomatic. No diagnosis or prescription were available hence we cannot comment on the rationality of the treatment. Practitioner utilisation by illness is presented in Figure 4.1

Sex wise distribution of treatment sought for illness during the past one month is presented in Table 4.9. The table depicts that:

1. Out of the 13 males who fell ill, all took some form of treatment, whereas out of the 23 females, five did not take any treatment.

2. Of the 13 males, eleven (85%) went to the private practitioner, whereas of the 23 females, nine (39%) went to the private practitioner.

3. Two males (15%) went to the P.H.C. for treatment while seven females (30.4%) went to the P.H.C.

4. No male approached the C.H.V. for treatment, while two females took treatment from the C.H.V.

Health Expenditure :

Table 4.10 (a) and (b) present the health expenditure by income of the household. Four households in Pondhe in the income category of Rs.201/- to Rs.400/- per month, reported a total of six illness episodes, making for an average of 1.5 illness episodes per family for the one month of recall. The average income of these four households was Rs.314.25/-. These households together had spent Rs.32/- on six illness episodes, accounting for Rs.5.3/- per episode and Rs.8/- per household. These households spent 2.54%- of their monthly income on medical care.

The data for the rest of the categories has been presented identically in Tables 4.10 (a) and (b), for the two villages.

The mean average and the median value of health expenditure per episode in Pondhe are quite similar (Rs.13.7 and Rs.14 respectively). In Mavdi, the median value is slightly lower (Rs.20) as compared to the average health expenditure per episode (Rs.26).

The practitioner wise health expenditure is presented in Figure 4.2.

Private health expenditure is very high. Within the past one week, two of the women present in a group meeting in Mavdi had spent Rs.50 and Rs.70 each on visits to private practitioners in Saswad. One of the women had fallen at the EGS site from the nalla. She has yet not been told anything about receiving monetary compensation. She went into shock and was taken to Dr. Kamble in Saswad. The other women started discussing whether compensation was due to her. Some said it was and the others said that since she had taken private treatment she was no longer eligible for any compensation. The second women (who spent Rs.70 in one day) had been hurt on the external genitals two years ago in the seventh month of pregnancy when she unknowingly sat upon a vessel. She needs periodic treatment, and spends as much as Rs.75 on one course of treatment without any permanent cure.

Faith Healing:

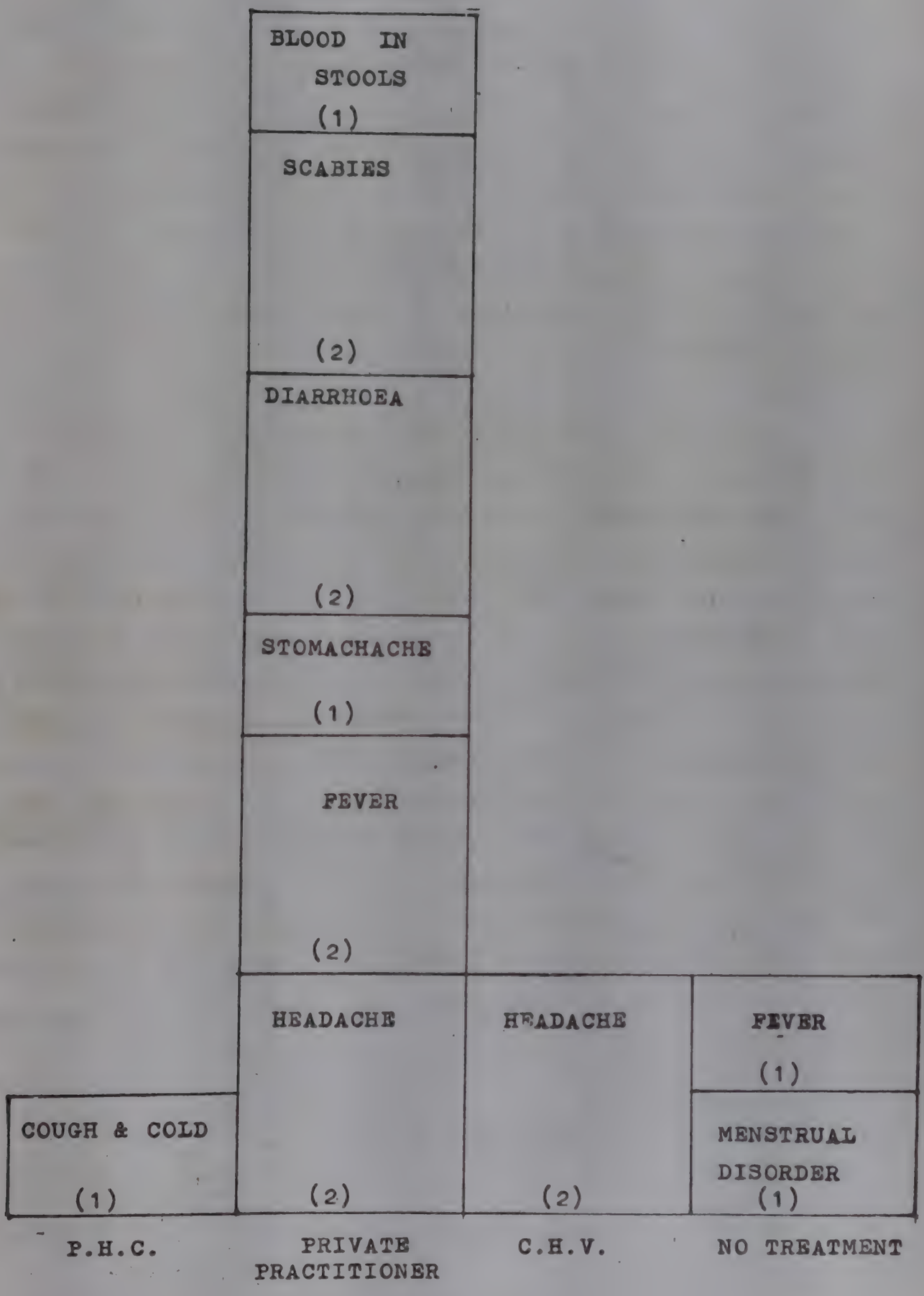
The faith of people in ritualistic healing is substantial, though the educated women denied such beliefs in our group meetings. Even health practitioners are aware of the hold that local 'Devrishis' (exorcists) have over perception and cure of illness (see annexure 5) We have attached at the end of this chapter an interview with a female devrishi in Mavdi (Annexure 6) and also some interesting abstracts from the Maharashtra State Gazetteers, Pune District (Annexure 7).

On a farm house mid-way between Malshiras and Pondhe village, we came across a woman who had a huge corn and an abcess on the back of her right palm. The woman had severe inflammation, sepsis and fever. We offerred to take her to Malshiras P.H.C. in our rented bullock cart, but she and her female relatives categorically refused to subject her to medical treatment. They said it was the curse of the local deity "Kalubai" (the black woman - probably a local altar of the 'Kalubai' at Mandhar, which the devrishi in Mavdi mentions in Annexure 7).

The above mentioned women said that the patient had attended a family wedding in Malshiras a few days ago. She had accompanied the bridal pair for blessings to the famous ancient shrine of Bhuleshwar on the outskirts of Malshiras village but had not sought the blessings of 'Kalubai' in the temple on a hill outside Pondhe. They were sure it was the fiery goddess showing her wrath because they said as an ill omen, a coconut from the sacred offerings at the wedding had fallen upon the injured woman's right hand, exactly where the abcess formed. They were afraid that medical intervention would only further aggravate the wound. The patient herself firmly believed that only strict penance would now appease the angry 'Kalubai'.

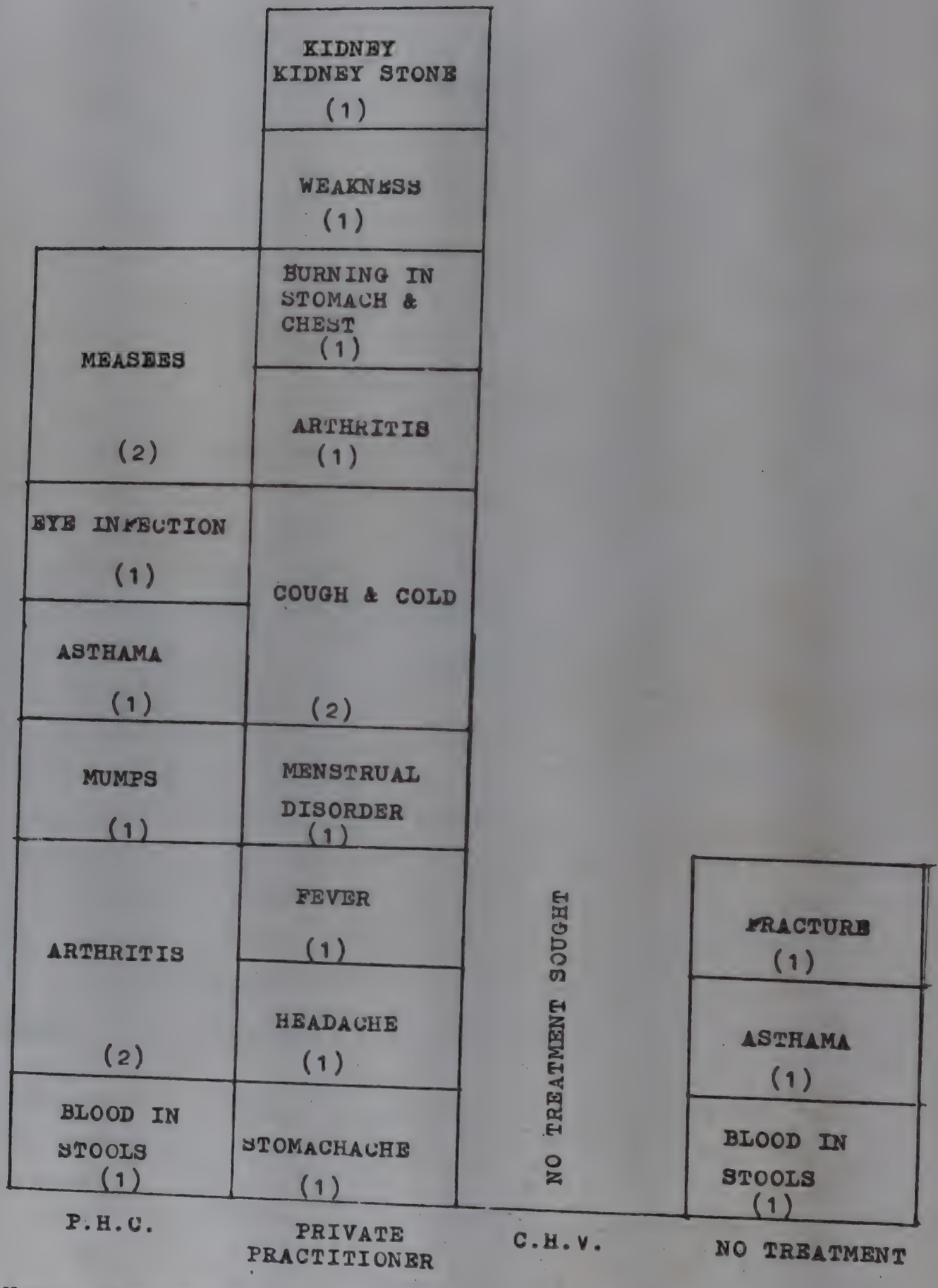
FIG.4.1(a) PRACTITIONER UTILISATION BY ILLNESS

PONDHE



Note: Figures in parentheses indicate illness episodes.

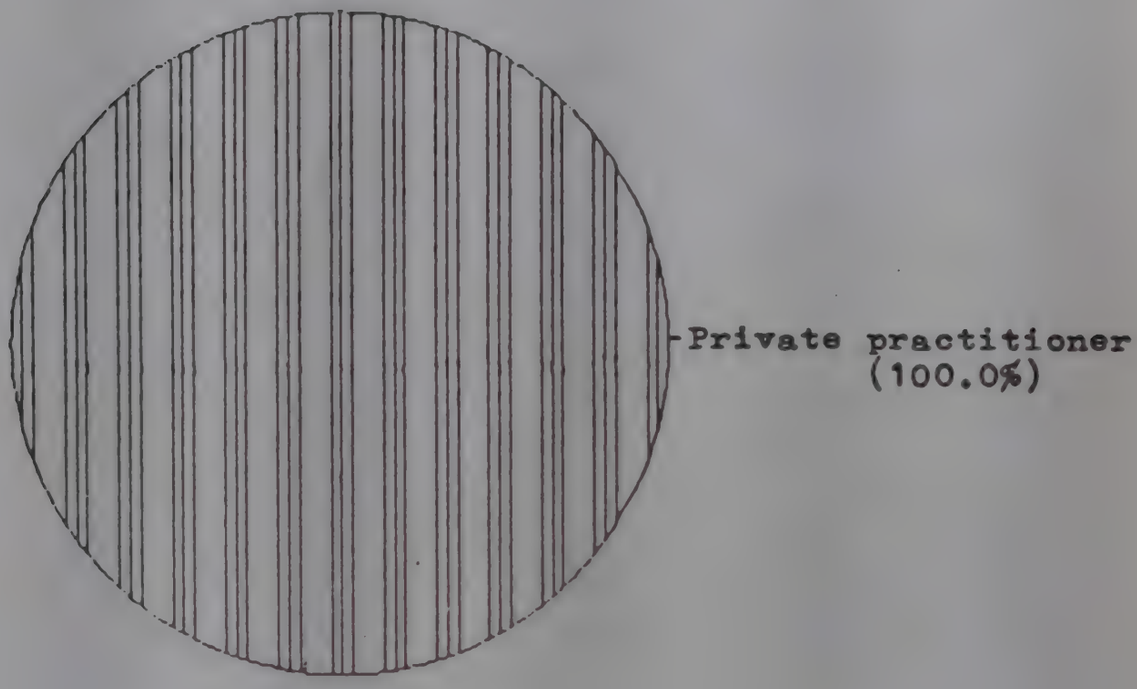
FIG.4.1(b) PRACTITIONER UTILISATION
BY ILLNESS
MAVDI



Note: Figures in parentheses indicate illness episodes.

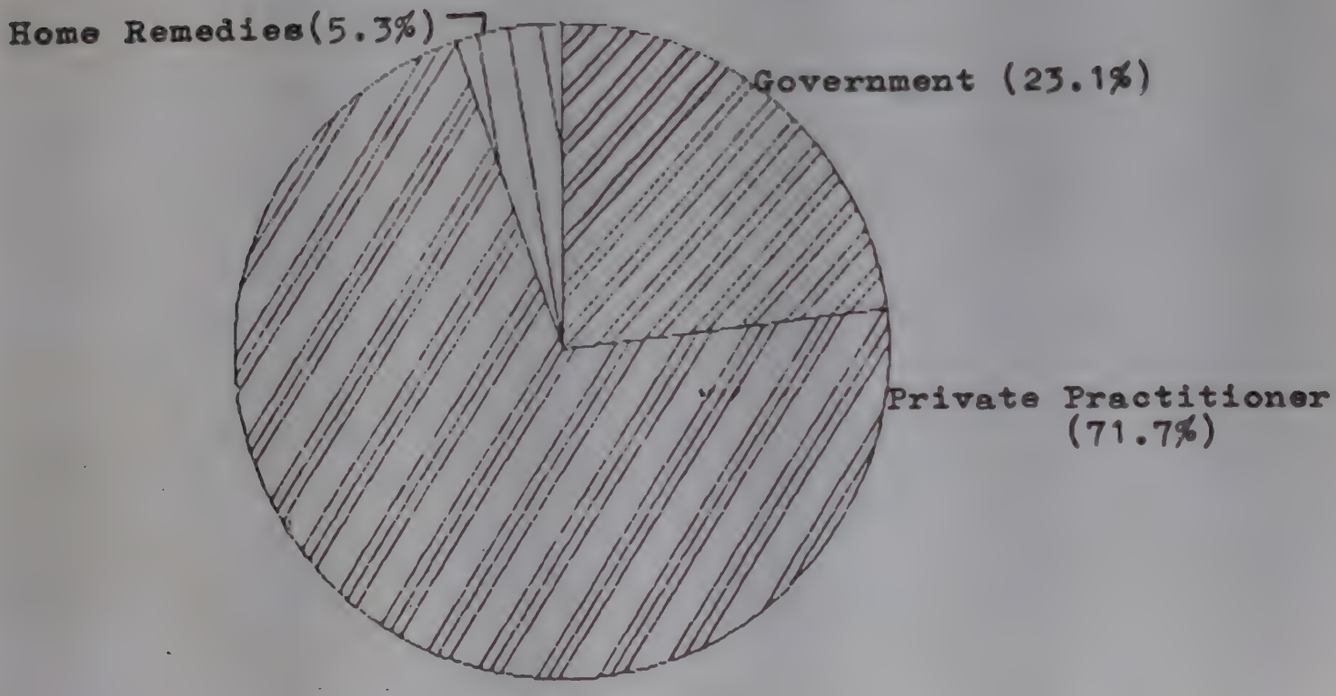
FIG·4·2(a) PRACTITIONER WISE HEALTH EXPENDITURE

PONDHE



FIG·4·2(b) PRACTITIONER WISE HEALTH EXPENDITURE

MAVDI



Annexure 1

Interview With Sr. Apte (Smt. Sudha Ganesh Apte)

Sr. Apte became a health practitioner in exceptional circumstances. Her husband a Subsidised Medical Practitioner (SMP) at the unit in Malshiras urged her to train as a midwife. He said it would help him in his work, too. "I never was interested in studying, leave alone nursing. But when my second child, a son died at the age of two years due to dysentry, it was impossible to sit at home and brood. So inspite of great family opposition, I went to KEM hospital in Pune in the year 1952. I kept my daughter, who was then six years old in a residential school in Pune (Huzur Pag). My husband stayed back in Malshiras and cooked for himself during the 1½ years that I was away. Neighbours were very cooperative, also, I finished my midwifery training at the age of 27 years and stood first in my batch. My lectures encouraged me to go to Sasoon Hospital for further training, but because of domestic responsibility I returned to Malshiras".

Sr. Apte then got a ZP appointment at a SMP unit in Baramati taluka of Pune district. She was there for six months after which she came to Malshiras and then served at the latter unit for 25 years until she retired. Each SMP unit had a staff of one doctor, one nurse midwife, one midwife, one sub sanitary inspector, one ayah and two attendants. UNICEF provided for the entire unit, including medicines, furniture, labour beds, bicycles for the staff and a kit for all health workers which even contained delivery packages.

Sr. Apte's husband (he died a few years ago of cancer) was a private practitioner until 1939. He married in 1940, and in the same year, he became a doctor in the local board. He served there until 1956. He received a salary of Rs.45 per month. Around that time the salaries of all doctors intending to become SMPs was gradually brought down to zero and thenceforth he received a small honorarium and was allowed private practice. At the SMP unit, he had to conduct a free OPD each day from 4-6 p.m. Every day he had to travel to one village. Mondays and Saturdays he had to stay at the SMP unit in Malshiras.

The NM and MW had five villages each. They alternated between headquarters and visits. For one week the NM would stay at the unit while the MW went on village visits. The next week they would reverse. This procedure continued. The nurse and midwife could take an attendant along. On these bicycles they would carry the free medicine and delivery kits.

In the village they had to cover 18 new households every day. A survey of infants, preschoolers, ANC women and all illnesses was conducted in these households to provide necessary intervention.

Until 1960 there were no immunisations except small pox. Earlier SP - vaccine was given by special SP workers. Later on nurses and midwives also administered this vaccine. The triple vaccines were introduced around 1960-62. Health workers had to maintain immunisation and other family records on cards as well as on

three registers (one for recording first visit, the second for expected necessary intervention in the following weeks/months and the third for actual follow up). Sr. Apte says that checking by higher officials was very strict.

Most immunisations were given at home. Sometimes a local place was used as OPD. All pregnant women had to be compulsorily registered in the fourth month for ANC. During the 4th, 5th and 6th months the health worker paid a monthly visit, in the 7th and 8th month a fortnightly visit and weekly visits were made in the 9th month. Sometimes, a Public Health Nurse (PHN) would accompany them to supervise their work. Strict rules had to be observed on each visit. For example all PHC cases had to be visited first, before regular visits to other households so that mother and child did not catch any infections from visits to ill persons' homes. The PHN observed if all proper inquiries were made, such as checking of mother's breasts, examination of child for thrush, whether the right questions had been asked about infant feeding and mother's diet.

Deliveries were mostly domiciliary. Hospital deliveries were extremely rare. Often relatives of the woman would arrive at night in a bullock cart to fetch Sr. Apte (at that time there were no buses or firm roads). The midwife and attendant would then return the next morning.

The major gynaecological complaints that Sr. Apte encounters in her private practice today are backache and leucorrhoea. The white discharge is not pus or smelly, but like 'lime stains'. Sr. Apte feels it is due to calcium deficiency during pregnancy and she gives a treatment of vaginal douches, vaginal suppositories of antibacterial nature and intra venous calcium injections.

Another gynaecological complaint is prolapsed uterus and lack of micturition due to urethral tears during delivery. She has come across a few cases of primary amenorrhoea and some of sterility. The most common outcome of sterility is bigamy and often husbands take second wives within a couple of years of marriage if there is no conception (or if there are only female children) without undergoing any check up themselves. She has however not come across any case of female infanticide in her entire career. However she knows of a couple of cases where neonatal infants were killed because they were born outside of marriage.

Whenever she comes across any case of incomplete abortion, she refers the woman immediately to Pune. But if the abortion has occured after five months of pregnancy and if the head is visible, then she conducts the delivery normally.

Speaking about indigenous methods of conducting abortions she knows of a woman in Tekawadi village who is a Devrishi and who gives herbs and oil massages for abortion. Sr. Apte knows of a number of women (all who had conceived outside of marriage) who have gone to her and who have aborted.

Even today, Sr. Apte feels that tremendous health education is required. Where contraception is concerned, most couples earlier practised coitus interruptus. Barrier methods like Nirodh are just dumped away because there is no privacy. She feels that contraceptives must always be given to women because men are not to be relied upon for avoiding conceptions. If a couple is motivated for sterilisation, even before the husband says anything, the woman opts for tubectomy saying that 'Vasectomy will harm him'. Inspite of vasectomy being much simpler to perform and being harmless, such myths prevail.

If a large placenta is ejected women believe that the pregnant woman was fed stale 'bhakris' (bread of unleavened dough of millets) by her mother-in-law. if the baby is covered with vermix then it is believed that sexual intercourse continued until the ninth month of pregnancy and therefore the baby is born with so much dirt. That is one of the reasons why pregnant women are sent to their natal households in the seventh month of pregnancy. It is still largely believed that if a woman eats well during pregnancy, the child is born thin and underweight.

Sr. Apte feels that health education should be through regular discussions with women, especially in ANC clinics. In 1967, they had been asked to establish Mahila Mandals on the SMP unit campus itself. One Gram Sevika who was very enthusiastic helped the health staff to organise regular weekly meetings. Sr. Apte was the president of this Mahila Mandal for 8 years. Not only

did the women discuss their health problems, but they had also started their own bank accounts, paying Rs.5 each month.

Sr. Apte feels that such a forum should be revived. She is enthusiastic about participating in such a group again and says that if anyone starts such group discussions in Malshiras or even in the neighbouring villages, she is ready to give her time for this activity.

-o-o-o-o-o-o-

Annexure 2

Interview With Sr. K.R. Upadhyay, Auxillary Nurse Midwife (ANM), Malshiras PHC.

Sr. Upadhyay along with Sr. Gaikwad (NM) handles the Out Patient Department (OPD) at the PHC. She works at the OPD four days each week. They handle around 50 patients each day, in this season when incidence of most infectious diseases (including conjunctivities) is high.

The sex wise distribution of patients in the OPD is almost equal she says. Among women, however, the average age is around 35 years. Female children are not very commonly brought, except for injury and fevers. The highest attendance among women is from the age group between 35 and 60 years. The commonest complaints among women is backache, weakness and leucorrhoea. The latter says is due to cervical infections caused by dirty water and unhygienic conditions and practices. Most people in villages use open spaces as latrines. Many do not use enough water. 'Even stones and pebbles are used to clean up after defecation. Small children are patted dry with cloth swabs and sometimes the swabs are just kept aside. The reason is that there is not enough health education. People say that they have no time. Health practices need to be changed'.

Seasonaly, monsoon (June to October) shows a high prevalence of fever with rigours and dysentery, followed by diarrhoea. 'People eat uncovered foods

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at work sites without washing their hands. If you ask them to wash hands before eating, they say 'your upper caste taboos of sovala are not for us'. ('Sovala' is a brahminical purity ritual where cooking is done by women, immediately after bathing in the morning and with wet clothes on. During the entire time that they are cooking, they cannot touch or be touched by anybody. Sovala is also observed during prayer).

When women have leucorrhoea they don't come to the PHC immediately. Firstly they wait for a month or so to confirm. Then they go to Devrishis for rituals and for herbs. Only if it persists after that they come for medical aid. 'Even for dogbites people go to Devrishis'. Fortunately she says that for immunisations including the antenatal TT injections there is good response from the people. Many young women even demand immunisations for themselves and their children. A generalised demand for any injections is also prevalent.

Worm infections are common, too. Often she says women comes with complaints of back and abdominal ache. That most often is threadworm infections. White patches on children's faces are very common, too. The reason, more than any deficiency is worm infestation. There are very few skin infections in this area. Even when scabies become endemic that is only seasonal and the scabies are dry, not oozing or open. The incidence of tuberculosis and leprosy is low. (9 TB cases - all old cases having completed treatment and 4 cases of leprosy in Malshiras village whose population is 3,000). Sr. Upadhyay says that they always refer to leprosy as a 'skin infection that will heal with regular treatment'. Otherwise she says the patient would be discarded by their own families.

Above the age of 60 years, asthama and breathing disorders are common. No sexually transmitted disease (STD) has been noticed or detected here. Men, Sr. Upadhyay feels have lesser health problems than women have. The major OPD attendance for males is injuries or fevers.

During her stay at Malshiras (June 1986 onwards), Sr. Upadhyay has seen very few spontaneous abortions and no "criminal" (sic) abortion. She does not feel that there is a seasonal variation in abortions. The PHC refers all MTP cases to Sasoon Hospital in Pune. Sometimes, conceptions do occur outside of marriage. The ANMs tell the woman in private that she is pregnant, report the case to the medical officers and then refer her to Yewat PHC which has MTP facilities. The PHC here however maintains a case paper for record.

Sr. Upadhyay has not noticed any specific occupation related diseases except injuries. She says that on an average at least 10-15 adults come each month with injuries which they have incurred at work sites.

On an average 6-7 deliveries are conducted at the PHC each month. Women prefer home deliveries. Those with obstructed labour are brought here. The PHC performs only normal, vaginal deliveries. If a Caesarean section is imminent, the woman is referred to Sasoon Hospital in Pune. People go to private hospitals in risky cases because they believe that 'private treatment is always better'. Sometimes a

delivery becomes high risk because the woman is anaemic or has a prolapsed uterus. Such deliveries are not conducted at the PHC, here.

There are many taboos during pregnancy and after childbirth. Pregnant women are not allowed to eat bananas, papaya, eggs and many other foods. Women after delivery are not given pickles, curds, gourds and they do not eat bananas for over a year. The reason is that some foods are supposed to cause abortions and that others are harmful to the breast feeding child. They are supposed to cause coughs and colds in the infant .

In the PHC, the sleeping position is insisted upon during delivery, 'We are taught to deliver in that position. The cervix is also prone to damage in squatting position'. Sr. Upadhyay feels that home deliveries are often very unhygienic. The traditional birth attendants probe into the vagina with fingers and cause infections and fevers due to their unclean finger nails. Vulval swelling is very common'. Sometimes, even the cervix is not visible due to swelling.

When asked if women did not resent being made to lie down on their backs during delivery, Sr. Upadhyay said 'They are brought from long distances in bullock carts because they need medical intervention. They come with the confidence that they will deliver safely in a hospital. So they listen to us'. The normal birth weight is 6-6½ pounds, except in cases of premature delivery. Breastfeeding is encouraged within three

hours of delivery. 'Even after Caesarean sections, breastfeeding should be introduced immediately'.

A small family norm is becoming more acceptable. However there is resistance to sterilisation from women who have 4-5 daughters. Often if the first born is a male, women accept sterilisation after the second delivery, whether boy or girl. But if a woman has many daughters and no sons, she cannot be convinced easily even if the sixth child is a male. She then insists on one more male child'. There are at least 7-8 cases that I know of who are waiting for male children'. People from this area do not go for sex determination of the foetus. 'That is because they are far away from Pune. Those who live closer to Pune certainly go for these tests'.

Before coming to Malshiras, Sr.Upadhyay has worked only in subcentres. This is her first PHC appointment and she feels that she gets much more experience here. She has been an ANM since 1970 (since before her marriage). Earlier she was at Khanpur, very close to Pune, near Khadakvasla. She recalls that a good health education team used to visit villages near Khadakvasla. That was a military team from Vanwadi. They had excellent education material and the nurse used to conscientiously visit the area for three months each year. 'They would come in a van with their own food and water. They never ate in the villages. They were competent, only they spoke in Hindi so the villagers could not follow any of the lectures'. She feels that such work is necessary to change people's attitudes towards illness and health.

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Annexure 3.

Interview with Shri Nivrutti Gunjbhare, CHV, Pondhe. (Age, around 55 years).

Shri Gunjbhare is a Gurav by caste and therefore performs the pooja in the village temple, twice daily. He has agricultural land, rainfed and not of much use because of drought. He makes mithai (sweetmeats) and sells them in neighbouring weekly bazaars, especially the Friday bazaar at Yewat. He also makes patrawalis and dron (plates and bowls made of leaves stitched together) - for sale (Rs.10/- for 1000 pieces).

The Gram panchayat decided that he should become CHV and therefore in 1980 he was sent to Saswad for three months training. He stayed there and was paid Rs.200/- per month. After that he has been getting Rs.50 per month. He complained that it was not enough 'barely Rs.1.25 per day', but he said that the union was active to get more remuneration. 'Two of our CHVs, one male and one female are very active in the union. For one month last year all male CHVs were disbanded. We didn't work. Then we were asked to resume work and were also paid for the entire non-working month'.

For continuing education, he was called to Saswad 8-10 times, but he could not go 'because of lack of transport'. In Malshiras PHC there has been no continuous education. All CHVs have a monthly meeting at the PHC (on the sixth of every month) where their work is reviewed, records checked and honorarium is paid.

About 2-3 years ago, Shri Gunjbhare recalls that there was a hepatitis epidemic in Pondhe. About 30 people were affected. One woman died. Immediately a government team was summoned. They immunised people, took water samples and checked the epidemic. Asked if he can disinfect water sources, he said he can't, besides he said that no disinfecting powder was available to him.

For the past three to four months, he has received no medicines. No regular immunisation camps are held in Pondhe, he said in normal circumstances they get a medicine kit from the PHC every three months.

The main illnesses in Pondhe he said are diarrhoea, fever, cold and cough. 'We had tablets to cure diarrhoea earlier, now we do not have any with us'. At the village chowk we saw him give soda mint for diarrhoea.

He spends 1-2 hours daily to do his CHV's job. He says that he records the number of pregnant women and illnesses in the family. He refers illness cases to the Malshiras PHC - he does not make any growth charts for under five children.

As CHV he has to take cases for tubectomy. He has not been able to motivate a single woman for copper-T insertion, 'Women don't like Tambi. They prefer sterilisation'. Until now he has taken 5-6 tubectomy cases to Malshiras PHC. All of them were 'taken away' by the MPW. Once he managed to motivate

a male for vasectomy. On the same evening, the BDO's car came along and 'took' his case away. Asked why he allows such snatching he said 'They are all big officers. I can't say anything'! He said that CHVs had complained to the PHC doctors and the latter had said that they would look into the matter.

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Annexure 4.

Interview of Shri Rajguru Appa, CHV, Mavdi - Supe.

In 1980, the village panchayat decided to select Shri Rajguru to be trained as the CHV of Mavdi because of his inclination and involvement in social issues. He is a Gurav (priest) as well as a trustee of the local temple. Through this temple fund, people are given loans for agricultural production. He underwent a three months training in Saswad (there was no PHC in Malshiras, then), and was paid Rs.200 per month as a stipend during that period. After the training, to date he gets an honorarium of Rs.50 per month. Since 1985, he has been reporting to Malshiras PHC. As a CHV, Shri Rajguru has been dispensing medicines, keeping birth and deaths records, motivating for FP, gathering children for immunisation and assisting senior health workers in their duties. For the past six months, he has not received any medicines, except chloroquin. Often he has to give these tablets for all ailments to maintain his credibility with the people. He has bought benzoin and iodine at his personal cost which his family members and villagers use.

As an occupation, Shri Rajguru does oil and engine repair work. He also does some fitting and repairs of the two local flour mills. He conducts poojas. He has four acres of rainfed land on his own name. Asked how he manages to be a CHV along with so many other responsibilities he says that people come home for medical aid. 'My wife too can dispense, now. I don't have to move

around much except for collecting records and to gather children. Mavdi is a small village with no wadis. Besides, I know every family well since childhood. So work is not 'difficult'.

Speaking of health problems of Mavdi villagers, he says that bodyache, fever with chills and headache are most common. Most of these he attributes to hard labour on EGS sites. Leucorrhoea is the most common gynaecological complaint. A woman of 40 years having two sons a daughter recently had to undergo a hysterectomy in a private clinic in Bombay due to leucorrhoea. Two more hysterectomies were performed, both in private hospitals in Pune for the same reason.

Asked about facilities for deliveries, he says that there is no suin in Mavdi. There was an old Chambhar midwife who died of old age. She was very good and all castes utilised her services. One woman was trained in Malshiras for one month as a dai in 1979. 'She doesn't understand a thing about deliveries and so no one calls her'. Older experienced women of most households conduct neighbourhood deliveries. Complicated cases whether of deliveries, gynaecological or medical nature are first referred to Jejuri and then to Pune. In all cases invariably people are sent to private practitioners and not to Malshiras PHC. Though the Jejuri PHC has better performance and access than Malshiras, according to Shri Rajguru, he feels that treatment in private clinics is always better than in

government centres. 'Tablets, injections, all are better in private dispensaries. In my own case, a few days ago my septic finger wound proved the same'.

Asked about problems in motivating for FP he said that most young couples voluntarily opt for sterilisation after 2-3 births. He does not nag anybody. As a CHV he is not under compulsion to complete targets. Some couples (especially tubectomies after delivery) gets sterilised throughout the year, whereas others (especially vasectomies) wait for large camps at the end of the financial year when incentives are highest (even upto Rs.500 per vasectomy). However he said the main problem was that MPWs and ANMs snatch away FP cases from CHVs. They tear away forms filled by CHVs and fill in new ones with their own names as motivators.

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Annexure 5.

Interview with Dr. Vinod Ramchandra Shitole, private practitioner (RMP) from Naigaon, who visits Pondhe and Mavdi once a week, each.

Dr. Shitole travels to Pondhe every Wednesday morning on a motorbike. He lives in Naigaon. He visits Mavdi as well as many other neighbouring villages such as Pisarve, Amble, Rajuri and Tekawadi. He says that people in Pondhe used to go to the bank in Naigaon and since they knew that he was an RMP, they asked him to visit Pondhe. That's how he started going there. Mavdi is much closer to Naigaon.

There is a lot of blind faith in Pondhe, Dr.Shitole says. Some people will go only to Devrishis (Bhagats). If the Devrishi says that no medicines should be taken, then people will not take them. However, he has yet not had any resistance from Devrishis because he does not antagonise them. Many others do not seek allopathic medical care immediately. They go to him only when an illness cannot be cured by 'faith'. Illnesses of children (mainly stomach ailments) are no exception. He says that he has to be very careful in his practice, 'If results are good, then people do not create any trouble' he says.

'Economic deprivation is another reason why people cannot seek immediate medical intervention, often the disease itself is a result of apalling economic conditions.

For example, he says among women stomach ache and backache is very common. They attribute it to tubectomy. The real reason is lifelong malnourishment, especially after each delivery, when women return to work within eight days. This has an adverse effect on their health. Very few women have health problems such as 'vaat' due to obesity. Most women are thin and illfed.

In such cases, Dr.Shitole gives B-complex tablets and injections and prescribes tonics. 'I know that the real education should be about enough food, but that is not possible. Only when I prescribe tonics people take weakness seriously'. In addition to bad health conditions of women, they fast regularly for religious purposes. Some only have tea throughout the fasting days. So they do not have any resistance to fight disease and fall ill even more often.

Influenza and dysentry are very common illnesses. There is malaria too, though not very rampant. Generally dysentery spreads during the rains, cough and cold in winter and influenza is seen at each change in season. Among women the most common gynaecological disorders are irregular bleeding and leucorrhoea. Wounds are very commonly seen here, especially among outdoor workers'. They work with stones and implements'. Dr. Shitole has not observed any illnesses specific to the wage earning population. Infact he says that more health problems are seen with occasional workers, because their body is subjected to sudden strain and shock. Regular workers are used to very hard labour.

He keeps TT injections with him, but only for wounds. He does not deliver any ANC. He stitches wounds and applies bandages, but does not conduct surgeries. Nor does he conduct any MTPs or deliveries. He refers all such women to Saswad, Yewat or to Jejuri. He does not do any FP work (sterilisations, copper-T) but gives FP advice.

Speaking about people's mania for injections, Dr. Shitole says that people have preferences. While some people want only injections, others want only tablets. He does not encourage intravenous injections. As far as possible he prefers oral medication. Even in dehydration cases, he prefers glucon-D, glucon-C or other 'Glaxo products' orally. 'IV has high risk of unnecessary infections'. In diarrhoea or dysentery, he gives Electral powder. He also makes Electral solution 'in boiled water' and gives that to the mother in a bottle so that she can rehydrate the child. Asked about teaching simple ORS, he says that 'people just nod, but do not take the trouble to prepare it. It is better not to take a risk, that's why I give a ready made solution'.

Dr. Shitole says that good clinical results are obtained with tetracycline, analgin, penicillin (for large wounds, ear infections etc.) - he 'always tests penicillin prior to injecting', B-complex and Sequil, Avil does not show such good results. However, health education is required before giving Sequil. Otherwise drowsiness causes panic among patient and relatives.

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Annexure - 6.

Interview with Smt. Phulabai Shankar Sulaskar, the Devrishi (exorcist) in Mavdi village. (Age - around 55 years).

Phulabhai was very reluctant to speak when Rajguru Appa (the CHV) called her. She kept referring to the Manvat murders and said that she did not believe in animal or human sacrifices, neither did she practice black magic. She kept asking as to what the motive of the interview was and whether we had been sent on an enquiry regarding, some 'trouble'. However after half an hour of general conversation she relaxed and agreed to speak. She maintained throughout that she doesn't demand any money, only takes whatever (money, bangles, grain or clothes) people may give on their own.

Phulabai was married into Mavdi village two years before menarche. Soon after her marriage, her husband went to Mandhar village to attend the annual jatra (fair) of the goddess Kalubai (the Black woman) on the full moon day of the Hindu month of Paush (December-January). At that time Phulabai, for the first time started being possessed by Kalubai. She would grit her teeth and go into a trance leading to stupor. So her husband's eldest brother (the head of the household) took her to a famous Devrishi near Mavdi. The older Devrishi 'examined' her to find out if she was possessed by a god or a ghost and to find out the name of the possessing spirit. He kept a row of lemons,

naming each one mentally and then asked her to choose one. Phulabai chose Kalubai. The older Devrishi was pleased because he was a Kalubai medium himself. He then gave her some angaara (ash) to keep. After that Phulabai was cured of the possessions.

When they returned home, the brother-in-law established an altar of Kalubai inside the house as a mark of respect for the goddess's 'presence' in their home.

Years later (after her children had grown up and past her own menopause), Phulabai started 'seeing' the goddess. Kalubai appeared in a dream, standing close to her pillow and told her that she was passing on intuitive powers to Phulabai. Ever since then, Phulabai can foresee or predict occult events. She has been practising this art now for over 10 years. When asked as to why these powers could not come to her earlier, she said "where was the time? I was so busy bringing up my children and working".

Phulabai 'tells events related to sterility, alone. Women who have not conceived for some years after marriage go to her. Phulabai goes into a trance and asks the woman to speak out as to which spirit is bothering her by describing locations and spots in the village where the woman feels strange, uneasy and afraid. This is based on the theory that there are seven invisible sisters called the 'Mavlya' (singular - Mavli) who inhabit certain locations in the village. They are

found on trees, having preferences for some trees such as the banyan, neem, lemon and peepal trees but their favourite residence is close to water. They may therefore be found hovering around ponds, wells or rivers and if they find an unsuspecting young woman alone, especially around midday and midnight they possess her and cause sterility.

When the woman confides in Pulabai, the latter states as to which Mavli is harrassing the woman. She then tells the woman to prepare a tray that contains three pulses that are sprinkled with black and white (for example coal and lime powders) and to offer these, along with haldi and kunku (turmeric and vermillion) at a certain spot for five consecutive full moon days for a particular 'Mavli'. Phulabai also gives the woman some gomutra (urine of cow) and a lemon that is exorcised by her. That appeases the Mavli and she then deserts the woman. Sometimes Phulabai asks the woman to establish an altar of Kalubai in her home. When asked if she suggests any special days for sexual cohabitation to the woman, she said that she did'nt.

She says that on an average she has one woman go to her each month. There are very few males who seek her advice. Asked if she could diagnose other problems such as skin eruptions and boils (they are supposed to be caused by Mothi Aai - the Big Mother and they are supposed to get much worse if medical aid is sought) she said 'Mothi Aai does not tolerate non vegetarianism

so I cannot be possessed by her. Only vegetarian 'gowlis' (milk sellers) can be blessed by her'. She does not deal with gynaecological ailments such as leucorrhoea.

When asked as to how often she goes into a trance, she said 'Only when somebody comes to me with a problem. However, during each Paush, we leave for Mandhar village in a bullock cart two days before the full moon day. As we approach Mandhar and I hear the Aarti (chants) and drumbeats of the believers, I go into a trance. Thousands of people like me are in a trance for about five days. Over a hundred thousand people gather there each year for the Jatra to pay homage to Kalubai'.

Phulabai says that she has had success in curing the sterility of many women in Mavdi. However if she feels that she can't handle a case she refers them to Jejuri and Pune for curetting. Bites of dogs, scorpions and snakes are also well treated through ritual, Phulabai says. The victim is taken to the village temple of Natha. Villagers gather, beat drums, play the lezhims and amidst a lot of noise they encircle the patient and the god five times. 'Most often, the patient revives', Phulabai said.

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Annexure - 7

Abridged from the Maharashtra State Gazetters, Pune District.

The religious faith of the Hindu agriculturists and labourers (i.e. the rural population in general) is a curious mixture of animism and tenets of Hindu religion. They follow the Hindu law of inheritance and call themselves Hindus. Many of them are "Varkaris", who are also called "Malakaris" as they wear necklaces of basil beads. They worship all Brahminic gods and goddesses, but their chief objects of worship are Bhairav, Bhavani, Biroba, Jakhai, Janai, Jokhai, Kalkai, Khandoba, Maruti, Metisai, Mhasoba, Mukai, Navlai, Phirangai, Satvai, Tukai, Vaghoba, and Vetal, whom they greatly fear and whose images or 'taks' they keep in their houses.

Bhairava is the usual village guardian. He is encircled by a serpent. If kept pleased by a coating of oil and redlead and given offerings of 'ghee', Bhairava is kindly. He cures snake-bites and tells whether an undertaking will do well or will fail. Twice a year, before they begin to sow and before they begin to reap, the villagers go in procession and worship Bhairava.

Bhavani, the wife of Siva, shares with Bhairava the honour of being the village guardian. She is known by many names such as Phirangai, Tukai etc. and is generally shown as a rude image. Through an oracle, she is asked the cause of sickness or ill-luck and to advise regarding the future, and like Bhairava, if she removes trouble or advises well, she is given a goat or a cock.

Biroba is worshipped mainly by Dhangars or shepherds. He lives in an unhewn stone outside of the village. He is an unkindly spirit to whom people pray when they are anxious to plague or ruin their enemies.

Jakhai, Janai, Jokhai, Kalkai, Metisai, Mukai and Navlai are all local "mothers". They are unkindly forms of Bhavani who blast crops of grain, plague men with sickness and carry off travellers. People who owe their neighbours a grudge pray to Janai, Mukai or one of the other "mothers" to send them sickness, to kill their cattle or to ruin their fields.

Khandoba guards the country as Bhairava guards the village. Khandoba is the 'Isvar Dev' or guardian deity of the Deccan. He drives away evil which causes sickness. No class honour Khandoba so highly as the Ramosis. If a Ramosi makes a promise while laying his hand on Khandoba, nothing will bring him to break the promise.

Mhasoba is perhaps the commonest and most widely feared of the local evil spirits. When sickness falls on the village, the people go to the village guardian and ask him a series of questions, which he answers by dropping a betelnut or by some other sign.

Satvai, or Mother Sixth, is the goddess of pregnant and lying-in women. She is worshipped by barren women and by lying-in women on the fifth or sixth day after the child is born. Her image is an armless bust.

The belief in spirits, withcraft and the evil eye has a great effect on the lives of the people. If the person is seized with uncommon sickness or suffers from calamity, he first finds out whether his misfortunes are due to natural causes, to the displeasure of the gods, to withcraft, or to the evil eye or to an evil spirit.

The evil eye is much feared. The owner of the eye is not thought to blame, but he is shunned and cattle are not driven past his door. To draw the evil eye from the crops a whitewashed pot is stuck on a pole; the walls of houses are decked with figures and gaudy stripes; beautiful women and children wear necklaces, and cattle wear necklaces and anklets.

Every place teems with ghosts and evil spirits, who are included under general term 'bhut', literally a being. The male ghosts are called 'khavisas' or 'jhotingas' and the female ghosts 'hadalas'. Among the worst female ghosts are the seven water-nymphs called 'Aija' or 'Jaldevtas', who carry off handsome youths. The ghost enters into the culprit, maddens him, destroys his sleep, kills his family and turns his joy to sorrow. Many people make a living by appeasing or casting out angry spirits. One plan for the exorciser to take the possessed person in front of an idol, to seize him by the top-knot, scourge him and abuse him till the spirit says what offering or penance will satisfy him.

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CHAPTER - 4

Tables

Awareness and Utilization of Government Health Services

Table: 4.1 Primary Health Care

Awareness and Utilization	Pondhe Households		Mavdi Households	
No knowledge	1	(5)	-	-
Knowledge only	13	(65)	16	(55)
Knowledge & Utilization	6	(30)	13	(45)
Total	20	(100)	29	(100)

Note: Figures in parenthesis indicate percentages.

Table: 4.2 Health Workers

Level of Awareness	Pondhe Households			Mavdi Households		
No-knowledge	12(60)	20(100)	- -	.10(35)	29(100)	- -
Partially correct	8(40)	- -	20(100)	.19(65)	- -	29(100)
Correct knowledge	- -	- -	- -	- -	- -	
Total	20(100)	20(100)	20(100)	29(100)	.29(100)	29(100)

Note: Figures in parenthesis indicate percentages.

Table: 4.3 Utilisation of the Health Workers' Services

Utilisation	Pondhe		Mavdi	
	M.P.W.	C.H.V	M.P.W.	C.H.V.
No utilisation	19 (95)	4 (20)	22 (76)	2 (7)
Medicines for Minor illness	- -	15 (75)	1 (3)	27 (93)
Medicines and advice	- -	1 (5)	- -	- -
Blood testing	1 (5)	- -	- -	- -
Immunization	- -	- -	6 (21)	- -
Total	20 (100)	20 (100)	29 (100)	29 (100)

Table: 4.4 Peoples' Preference of Medical Treatment

Treatment Sought from	Pondhe			Mavdi		
	Minor ill-ness	Major ill-ness	Gynaec com-plaints	Minor ill-ness	Major ill-ness	Gynaec com-plaints
P.H.C.,Malshiras	10 (50)	2(10)	3(15)	10(35)	- -	- -
P.H.C., Saswad	- -	- -	- -	- -	2(7)	1 (3)
P.H.C., Jejuri	- -	- -	- -	17(59)	9(31)	14 (48)
*Pvt.Pr. Yewat	9 (45)	17(85)	16(80)	- -	1(3)	1 (3)
Pvt.Pr. Saswad	- -	- -	- -	1(3)	8(28)	3 (11)
Pvt.Pr. Jejuri	- -	- -	- -	1(3)	6(21)	6 (21)
Pvt.Pr. Pune	- -	- -	- -	- -	3(10)	3 (11)
No treatment sought	1 (5)	1 (5)	1(5)	- -	- -	1 (3)
Total	20 (100)	20 (100)	20(100)	29(100)	29(100)	29 (100)

* stands for Private Medical Practitioners who may or may not have a qualified medical degree.

Note: Figures in parenthesis indicate percentages.

Table: 4.5(a) Treatment sought for minor illnesses by socio-economic strata

Treatment for Minor Ailments	Pondhe			Mavdi		
	High %	Middle %	Low %	High %	Middle %	Low %
P.H.C., Malshiras	-	42	71	-	22	100
P.H.C., Saswad	-	-	-	-	-	-
P.H.C., Jejuri	-	-	-	100	70	-
*Pvt.Pr. Yewat	100	58	14	-	-	-
Pvt.Pr. Saswad	-	-	-	-	4	-
Pvt. Pr.Jejuri	-	-	-	-	4	-
Pvt.Pr. Pune	-	-	-	-	-	-
No treatment ever sought	-	-	14	-	-	-

* Pvt. Pr. stands for private medical practitioner who may or may not have a qualified medical degree.

Table: 4.5(b) Treatment Sought for Major Illnesses by Socio-Economic Strata

Treatment for Major illness	Pondhe			Mavdi		
	High %	Middle %	Low %	High %	Middle %	Low %
P.H.C., Malshiras	-	8	14	-	-	-
P.H.C., Saswad	-	-	-	-	9	-
* Pvt.Pr. Jejuri	-	-	-	-	27	60
Pvt. Pr.Yewat	100	92	72	-	4	-
Pvt. Pr.Saswat	-	-	-	-	30	20
Pvt. Pr.Jejuri	-	-	-	-	26	-
Pvt. Pr.Pune	-	-	-	100	4	20
No treatment ever sought	-	-	14	-	-	-

* Pvt. Pr. stands for private medical practitioner who may or may not have a qualified medical degree.

Table: 4.5(c) Treatment Sought for Gynaecological Complaints by Socio-Economic Strata

Treatment for gynaecological complaints	Pondhe			Mavdi		
	High %	Middle %	Low %	High %	Middle %	Low %
P.H.C., Malshiras	-	8	29	-	-	-
P.H.C., Saswad	-	-	-	-	-	20
*Pvt.Pr. Jejuri	-	-	-	-	44	80
Pvt.Pr. Yewat	100	92	57	-	4	-
Pvt.Pr. Saswad	-	-	-	-	13	-
Pvt.Pr. Jejuri	-	-	-	-	26	-
Pvt.Pr. Pune	-	-	-	100	9	-
No treatment ever sought	-	-	14	-	4	-

*Pvt.Pr. stands for private medical practitioner who may or may not have a qualified medical degree.

Table : 4.6 Illness Episodes (Mid May to Mid June, 1987)

Illness during the past One month	Pondhe Episodes	Mavdi Episodes
Stomach ache	1 (7)	1 (4.8)
Headache	4 (26)	1 (4.8)
Fever	3 (20)	1 (4.8)
Menstrual Disorders	1 (7)	1 (4.8)
Cough and Cold	1 (7)	2 (9.5)
Diarrhoea	2 (13)	-
Scabies	2 (13)	-
Blood in Stools	1 (7)	2 (9.5)
Arthritis	-	3 (14.2)
Burning sensation in the chest and stomach	-	1 (4.8)
Mumps	-	1 (4.8)
Asthma	-	2 (9.5)
Eye infection	-	1 (4.8)
Weakness	-	1 (4.8)
Fracture	-	1 (4.8)
Kidney stone	-	1 (4.8)
Measles	-	2 (9.5)
Total illness episodes	15(100)	21(100)

Table : 4.7 Illness By Age of Individuals

a) Pondhe

Age Group	Illness								
	Sto-mach ache	Head ache	Fever	Mens trual Diso-rder	Cough and Cold	Diarr hoea	Sca bies	Blood in Stool	Total
Less than 1 year									-
1 year to 4 years			1						1
5 years to 14 years		1			1	2	2		6
15 years to 24 years									-
25 years to 34 years		1		1				1	3
35 years to 44 years									-
45 years to 54 years		2	1						3
55 years and above	1		1						2

Table: 4.7 Illness By Age of Individuals

b) Mavdi

Age Group	Illness															
	Stomach ache	Head ache	Fever	Menstrual Disorder	Cough and Cold	Blood in Stools	Arthritis	Burning sensation in Chest & stomach	Mumps	Asthama	Eye Infection	Weakness	Fracture	Kidney stone	Measles	Total
Less than 1 year															1	-
1 yr. to 5 yrs.							1								1	2
5 yrs. to 14 yrs.					1				1		1				1	4
15 yrs. to 24 yrs.																-
25 yrs. to 34 yrs.		1						1				1				3
35 yrs. to 44 yrs.				1												1
45 yrs. to 54 yrs.	1				1		1									3
55 yrs. & above			1			2	1			2			1	1		8

Table: 4.8 Illness By Sex of Individuals

	Pondhe		Mavdi	
	Males	Females	Males	Females
Stomach ache	-	1	-	1
Headache	1	3	-	1
Fever	2	1	1	-
Menstrual Disorder	-	1	-	1
Cough and Cold	-	1	1	1
Diarrhoea	2	-	-	-
Scabies	2	-	-	-
Blood in Stools	-	1	-	2
Arthritis	-	-	1	2
Burning Sensation in Chest and Stomach	-	-	1	-
Mumps	-	-	1	-
Asthama	-	-	-	2
Eye infection	-	-	-	1
Weakness	-	-	-	1
Fracture	-	-	-	1
Kidney Stone	-	-	1	-
Measles	-	-	-	2
Total illness episodes	7	8	6	15

Table: 4.9 Sexwise Distribution of Treatment

Treatment Sought from	Pondhe		Mavdi	
	Males	Females	Males	Females
Primary Health Centre	-	1	2	6
Private Practitioner	7	3	4	6
Community Health Volunteer	-	2	-	-
No treatment	-	2	-	3
Total illness episodes	7	8	6	15

Table : 4.10(a) Health expenditure
Pondhe

Monthly Income Category	Total illness episodes	Average illness episodes per household.	Average income	Total health expenditure	Health expenditure per illness episode	Health expenditure per Household.	Percent of monthly household income on medical care.
Upto Rs. 200/-	-	-	-	-	-	-	-
Rs.201/- to 400/-	6	1.5	314.25	Rs. 31.80	Rs. 5.00	Rs. 8.00	2.54%
Rs.401/- to 600/-	1	1	510.00	-	-	-	-
Rs.601/- to 800/-	2	1	731.66	Rs. 35.00	Rs.17.50	Rs.17.50	2.39%
Rs.801/- to 1000/-	1	1	972.50	Rs. 14.00	Rs.14.00	Rs.14.00	1.43%
Rs.1001/- to 1500/-	5	2.5	1241.25	Rs.125.00	Rs.25.00	Rs.62.50	5.03%
Rs.1501/-& above	-	-	-	-	-	-	-

Table : 4.10(b) Health expenditure
Mavdi

Monthly Income Category	Total illness episodes	Average illness episodes per household.	Average income	Total health expenditure	Health expenditure per illness episode	Health expenditure per Household	Percent of monthly household income on medical care.
Upto Rs.200/-	4	2	118.75	Rs.105.20	Rs. 26.30	Rs. 52.50	44.2%
Rs. 201/- to 400/-	6	1.2	309.30	Rs.139.80	Rs. 23.30	Rs. 28.00	7%
Rs. 401/- to 600/-	1	1	490.00	Rs. 50.00	Rs. 50.00	Rs. 50.00	10.2%
Rs. 601/- to 800/-	-	-	-	-	-	-	-
Rs. 801/- to 1000/-	4	2	889.99	Rs. 30.06	Rs. 7.50	Rs. 15.00	1.68%
Rs.1001/- to 1500/-	5	1.6	1181.04	Rs.124.00	Rs. 24.80	Rs. 41.30	3.49%
Rs.1501/- & above	1	1	2594.00	Rs.100.00	Rs.100.00	Rs.100.00	3.85%

P A R T E

A FEMINIST CRITIQUE

Our qualitative data as well as our quantitative findings clearly show that where monetary income is concerned, around twenty per cent of the households are solely supported by women's wages and another twenty percent are supported up to more than fifty per cent, by the women of the household, every month.

In fact on a global scale, an estimated 18.30 per cent of the world's families are supported solely by women, while in many others (up to 30 per cent families) the woman's wage contribution is a substantial component. (Wayne, 1985).

It is therefore fallacious to argue that the woman's wage is only supplementary to the man's wage in the family. However, the wage structure continues to be constructed on the preconceived bias that women are economic appendages to men (Rowbotham 1973). Such a wage construction therefore puts the woman in a disadvantageous position even before she enters the labour force as a wage earner. Even in the area of our study we found that in private majduri men get Rs.15/- per day whereas women get Rs.7/- per day for the same work and for equal hours of work. Therefore men go to private majduri and send their wives to work on the Employment Guarantee Scheme (EGS), where the wages are same for men and for women. Women are sent to EGS because of the daily coupons of wheat that each worker receives.

It is noteworthy that in spite of women being paid half as much as men are, in the final analysis they support the family's income up to more that 50%, at least in 40 households out of 100. It would therefore not be completely illogical to suggest that women put in more than twice the amount of paid wage labour outside the home as compared to men so as to bring in an equal or more amount of wages home every month. In this argument one has not even considered the fact that 100% of most women's wages reache home for household consumption, whereas at least part of many men's wages (sometimes even more, or all of the/ir wages) are lost on alcohol, cigarette or bidi smoking, gambling and o. :er expensive habits.

Where agricultural income is concerned we conisidered the man's and woman's contribution to be equal. Typical to many agrarian communities in India, even in the area of our study, we have seen that men do the ploughing and the sowing whereas the women of the household perform all other tasks on the field. Firstly they deweed the fields prior to ploughing and are present throughout : the time of sowing. Later on they transplant, harvest as well as thresh the grain without much contribution from men.

It is a well-known phenomenon that women contribute almost entirely except in a few isolated cases to non-paid domestic labour, that is, housework. In our area we have seen that women exclusively do the cooking, fetching of water and fuel, as well as the daily household

chores of sweeping, dusting, washing of vessels and clothes, as well as weekly chores such as cleaning the floor with cowdung. Men tend to share only in fetching of water and this is not universal. We have seen more participation from dalit men in fetching water and almost none from middle or upper caste Hindus. Some men may be forced to share in fetching of water when the wives menstruate but that is because of stigma attached to menstruating women rather than with the intention to help their wives. In houses where there are more than one woman the husband did not fetch water. The other women of the household help the menstruating woman. In a few households we have noticed men helping the women even to gather fuel for fire but generally the collection of fuel is primarily a woman's job.

The other aspects of social labour that the woman puts forward, and this also exclusively is child-bearing and child rearing. As our qualitative data will show women did not confide in their husband to share with him the knowledge of their pregnancy. It shows how alienated men are from their wives' reproductive function. Delivery of women almost invariably takes place in her mother's house. Therefore the contribution of the men either financially, physically or mentally in child-bearing is nil. Almost invariably the husband is absent at the time of delivery. Child rearing again is exclusively considered a woman's job and is shared by the woman in question with other women of the household, such as the sister-in-law and mother-in-law.

Let us now examine the status of women in all these various aspects of social labour. Starting from the most intimate social labour that is reproductivity and child rearing, it appears through our study as well as many other similar studies that a woman's control over her own sexuality, fertility as well as on the major decisions regarding the upbringing of her own children is shamefully low. We have seen in our study that many women who have not conceived within a few years after marriage have shown signs of depression and insecurity. The fact that bigamy is very common in our area would only add to their mental stress. Even at the time of having to undergo a sterilisation it is invariably the woman who undergoes the tubectomy.

In a pathetic instance in Pondhe, we saw the MPW discuss as to where the woman's tubectomy would be performed and everyone except the woman in question was allowed to speak. This woman sat behind the curtain with the new-born child in her lap and it is not surprising that she was mentally stressed. Women also show mental health problems related to sterilisation. As will be seen through our group meetings women show severe post tubectomal sequelae, amongst them the most common being menstrual chaos, backache, depression and leucorrhoea (white discharge). It is possible that many of these are etiologically caused by tubectomy and it is also possible that some of the above symptoms are not. What is important is that women associate these real symptoms to the fact that they were sterilised. It is the utter helplessness and ignorance of women regarding what tubectomy

has done to their bodies that causes this fear and trauma. In the woman's meeting in Mavdi women said that whereas all sterilised women showed severe health problems, those who had been forcibly sterilised during the Emergency showed even more severe problems. It is our finding that the fear and trauma, both physical and mental, caused by the invasion of the oppressive family and medical establishment are responsible for this suffering of these women.

In the group meeting in Mavdi, women also told us that in 8 to 10 cases in their village, post tubectomal problems had reached to such an extent that these women had to undergo hysterectomy (removal of the uterus). In fact one woman vividly expressed that "If a woman undergoes one operation (sterilisation) the other (hysterectomy) is inevitable". This is further illustration of the fact that the medical establishment, after having rendered the woman powerless through tubectomy, further controls her by performing an expensive and often unnecessary surgery over her body. The control over the woman's mind is also absolute.

Health policy in India, in fact even the Alma Ata declaration does not recognise women's problems to be any other than those concerned with maternity (Prakash, 1986). In the same paper the author argues that even the limited package of maternal and child health (MCH) services has not made a considerable impact on woman's health per se. Though this programme may have brought

down maternal mortality rates, anaemia and toxaemia continue to be the two primary causes of maternal deaths. The latter are outside the purview of conventional MCH and are rooted in the general health conditions of women (ibid).

Our data also reflects upon poor access to health care where women are concerned, even during those crucial months of pregnancy and childbirth. Most deliveries are still conducted at home and it is a distressing sight to see women in obstructed labour being carried helter skelter in search of medical care by nervous family members.

Most of the women in our study area deliver at home not because they want to but because they have no other choice. Though our interviews with various health practitioners (see Annexures after chapters 3 and 4) show a divided opinion about the problems related to home deliveries (vaginal tears, prolapse and infection), we ourselves have come to believe that there is not much glamour involved in rural home deliveries. Speaking of self help and home delivery in an urban or western context is one thing but undergoing childbirth oneself in a thatched hovel in darkness, dirt and drought without any access to trained health practitioners is quite another thing. If a woman delivering in a hospital is at the mercy of the medical establishment, the other woman delivering in the absence of electricity, water and aseptic handling is at the mercy of her own fate. The former situation may be undesirable, the latter could be fatal.

Our data has revealed that a woman pays a high personal price for the loss of each child that she has borne. Besides the agony, guilt and utter feeling of helplessness, she has to produce another child to replace the dead one. Even our small sample has clearly shown a relationship between death of children and the number of live births that a woman has undergone (Table: 3.7). When all the children survived, we found the modal value of live births per woman to be two. When one child died, she had four live births. In fact, every dead child meant the added responsibility of two more live births upon the woman.

In the absence of the woman exerting any control on the death of her children, in the limited space that she can exert an option, she gives birth to more children. As the risk factor of deaths increases, she exerts herself much further to create a counteracting buffer by undergoing an enormous number of conceptions. Even though we have found very little foetal wastage in our sample, (Table: 3. 1), it must be remembered that Maharashtra is a well performing state and that within the state, Pune district is one of the best. It is a saddening thought to imagine as to how many conceptions, abortions, still births and live births, a rural woman in India undergoes to finally have the desired family size of three children — two male and one female offspring.

The anti-women target-oriented population control programme further punishes the woman by inverting the pyramid. Instead of understanding the grief of the death

of a child or the delicate nuances of women's lives, sterilisations (invariably tubectomies) or other contraceptives, many of them dangerous, are peddled to the couple through incentives. We have reason to believe that women have to produce more children because some die or may die or that some may live but as sickly undernourished humans. We do not believe that more children die because women produce more children or that reducing births can avert deaths.

Tracing a full circle, we come back to our argument about access to health care. We understand that reproduction is not the central aspect of a woman's life but yet we also believe that during and around childbirth at least, women must receive the very best health services that the nation has to offer. It is a question of women's rights because after all they are performing an important social task. Besides, any 'failure' whether a still birth or a dead child, has the greatest implication upon women's bodies and their minds.

A high quality health care programme is also due to rural populations. Inadequate stocks of medicine at the PHC, lethargic health workers and the fact that government health services are invariably linked with family planning do not have a positive impact upon, access or utilisation of these services. Paltry daily wages earned after long hours of work in the sun have to be spent on private practitioners' fees, when it is the duty of any government to provide good health services to its masses. Simplistic slogans like "Health for All" do not go a long way in improving health conditions.

Going back to other non-paid social labour that a woman performs for her family, viz., housework, and agricultural labour in her own field, she is alienated both from the land and the house that her family possesses. In her natal household as well as in her husband's house the land and the house always belong and are transferred to men's names. In spite of almost exclusively contributing to the upkeep of her home, she is perennially under the overt or covert threat of being thrown out of the house. In fact that threat of being rendered without shelter, makes her stick to the family in spite of naked oppressions such as wife beating, alcoholism, bigamy on her husband's part, not to speak of other subtle oppressions, and all the physical and mental stress they would induce.

On the fields it is never the woman whose opinion will be asked as to which or how much grain should be sown that year or whether the family should buy or sell a pair of bullocks. Naturally she will not decide where the produce will be sold, at what price and what will happen to the income. In case of cash crops, her condition might even be worse off because all the produce is converted to cash upon which she has no control.

As a result of the fact that women possess no assets, either at home or in the fields, they do not get loans from co-operative societies or banks, either for production or consumption.

Where paid wage labour is concerned most of the women in our area attend EGS work. On any given day, women form 80% of the labour force on EGS sites. Though the Purandar taluka figure shows that 67% of the EGS work force is women, in reality, it is much higher because many men enter their own name on the muster, but send their wives to EGS sites while they go in search of more lucrative wage labour. Analysing the contribution of women's labour to EGS work in the above villages (Annexure), it is noteworthy that every afforestation, minor irrigation and road construction activity is mainly carried out by the women of this area. Extending this argument further, the fact that the public transport plies on the village roads or that the wells have received water even in this drought affected area in spite of a few showers this year is because of women's labour. The entire development planning of Purandar taluka will rest upon the potential labour power of the women in that area, as the plan will be finally implemented by women.

After a visit to EGS sites one finds that though the majority of the workers are female, there is no woman mukadam or mistry. Women do not decide the priority in EGS work in their own village, district, state or at the Centre. They have no say in policy making or planning of EGS activities in their area. In spite of the fact that mainly women labour have constructed the road from Malshiras to Pondhe and have spent months of backbreaking hours in the sun to complete this 7 km. road, they are not articulate enough to make a demand that a public transport should reach Pondhe.

It is not surprising that these women cannot become a strong political force. Logically, one would argue that if women contribute substantially to the family's monetary income, contribute on equal terms with their men in the family's production, if they contribute almost exclusively in child bearing and child rearing, they would be an indomitable force that could wield immense political power. Indeed they would be a vocal and progressive force if their political power had sharpened. Instead their power and political consciousness dissipates because of their multifold contribution to societal functions.

The various tasks that the woman performs act against the woman herself. At most times in her life the woman in our study area is performing five tasks, mainly paid wage labour, non-paid agricultural work, house-work, child bearing as well as child rearing. She performs these tasks simultaneously. The woman as against her male counterpart works not only on EGS sites but also within the home. These women return to housework within fifteen days of delivery and go out as wage labourers within one month of delivery. Even during the period when they are at home they perform an important social responsibility by nurturing the child.

In our group meeting when women were asked as to why they opted for tubectomy when vasectomy was much simpler they said that "our men have to work hard. Sterilisation drains a person of energy and we are afraid that our men will become weaklings. For women

it's alright. What work do women do anyway?". This low self perception of herself does not allow the woman to make feminist demands and to prepare a political agenda calling for her own liberation.

The fact that the woman produces and reproduces at the same time should logically lead to her being paid better or should add to her status. But her implementation gets affected because she reproduces and her reproduction gets affected because she produces. We have an example of a woman in Pondhe who in the fourth month of pregnancy got severe abdominal cramps and she aborted. Not only did she receive no compensation, but she lost her full day's wage because she left half way during the day. The authors of this report do not see reproduction as private or personal or something that is a necessary evil that women workers carry with them to the working sites. We believe that woman's reproduction is as much for society's sake as for her own and we believe that much of women's oppression is linked to the fact that production and reproduction are artificially cleaved. This man-made differentiation allows for selective subjugation and exploitation of women.

As long as a woman has no control over the small corner of her universe, be it the micro-cosm of her own body, be it the micro environment of her home, her field or work site, or be it macro environment of the realm of policy making and planning, she would never be able to take control on her own life. By taking control we mean a conscious effort to question and resist subjugation by exploitative forces. In the absence of her

being in charge of her own destiny it would never be possible for her to realise how great an economic or political force she constitutes. In the absence of this conscientisation she would be grateful for small favours, such as paltry minimum wages, maternity benefits for one month, or small maintenance amounts from her divorced ex-husband. While we fully endorse a woman's right to receive these benefits, however unfair or inadequate they may be, we feel that a woman's share in available resources is much larger than receiving patronising concessions. What she must demand and fairly receive is her rightful share.

We realise the importance of pro woman policy and legislation, at the same time implementation of the above at the field level is easier said than done. A woman's life is so linked to her work and equally so vice versa, that it is virtually impossible to separate the two. As a vivid example, we might see the case of child bearing which not only forms a central part of woman's lives in traditional societies but child bearing and the woman's body are an indivisible unit. Therefore any reform or law cannot be implemented unless a holistic view of women's lives is taken into consideration.

If this perspective is absent, unfortunately most well-meaning reforms work against the woman herself. For example, unless reproduction is considered as an important economic and social contribution by women to society, enforcement of maternity benefits gives the employer the choice not to hire women workers in the

first place. As long as domestic labour is considered as solely a woman's responsibility, women will be the first to lose jobs in times of recession.

Even in the small world where women live, be it the village or the family, all decision making bodies are patriarchial. Our experience in the study area and other villages in Maharashtra repeatedly shows that women are barred entry, either as participants or observers, into the apex bodies of the caste and community. All decisions regarding quarrels, land dispute or domestic feuds are taken up by these omnipotent councils, (for example, the village elders as a group in our area) and often the power of these local bodies far exceeds that of the country's judiciary.

All decisions concerning development of the village (which concerns both men and women) as well as those regarding wife-beating, alcoholism and illegitimacy, (which are specific to women) are taken without the participation of, and in the absence of women.

As long as patriarchy's hold over the minds and bodies of women is foolproof, it is a little optimistic to hope that top down policies will change women's condition dramatically. It would take a very strong woman to demand entry into her village council meeting, because an assertive or "aggressive" woman, being vastly different from the image of the ideal woman (head covered, soft spoken, docile and self-sacrificing), is the stereotype of the wanton. Such a 'catch twenty-two' situation,

wherein social conditioning prevents a woman from voicing demands, and not being able to articulate demands reinforces social conditioning, is not conducive for solving women's problems. To be able to challenge the citadels of patriarchy, contradictory as it may sound, what is required is the formation of all-women-groups. These groups (we hesitate upon the word "mahila-mandal") since this term has the connotation of a government sponsored, target fulfilling activity where women gather to sing hymns or for cookery demonstrations) would be women's platforms exclusively. In the absence of men's presence women would learn to tackle their problems from a woman's perspective.

We have made the above argument to increase space for women, not to reduce it. Therefore, we also strongly recommend that women be taken on all decision-making bodies that have hitherto been exclusive male domains. Women ought to be represented in good strength on all EGS bodies at the village taluka, district and state levels, not only because women form the bulk labour force on EGS but also that development through EGS is as much women's business as it is that of men.

When the woman puts in a considerable energy in the creation of surplus and of social capital it would be logical to assume that she wields decision making power at least about her health, her work and utilisation of valuable resources. Ironically in the case of a woman it is because of the fact that she puts forth wage labour that her domestic duties get pushed to pre dawn and post

dusk hours. It is because of the fact that she goes out to earn a living that she cannot attend the O.P.D. of the primary health centre, since the PHC works for those same hours that she herself works. She has to postpone her decision of conceiving, and she has to force her eldest daughter to leave school to look after the younger children. This woman, constantly on a tight-rope would not be able to stand up and demand her equal share of existing resources, unless her labour is shared.

However cliched it may sound, the political consciousness of women would form in a cogent fashion, only when their domestic labour is socialised. When society shares the responsibility of this social labour which the woman bears exclusively, only then would a woman realise her political strength. We realise that it is not possible for a patriarchial structure to share this responsibility on its own, quite understandably, because such sharing threatens the very foundation of the institution of the family, the latter being based on the sexual division of labour. The solution would lie only in relevant women getting together in groups and sharing the task of their own liberation. As a first step, simple structures like community kitchens and creches, would give women some breathing space. Women could demand that the government bear the expenditure of these activities.

In a more advanced stage of collective effort, women could then get together to question all norms and institutions that determine their lives, their work and the very concept of sexual division of labour. Only at

this stage would it be possible for women to voice their political demands, to refuse alms and to demand what is their due.

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APPENDIX

WOMEN'S WORK, FERTILITY AND ACCESS TO HEALTH CARE

(A copy of the structured interview schedule)

AROGYA SHIKSHAN KENDRA
(Affiliated to F.R.C.H., Bombay)
At & Post : Malshiras
Tal. Purandar, Dist. Pune 412107

Schedule No. ☐☐

Name of the investigator :
Date of Interview :

I. IDENTIFICATION DATA

1. Name of the respondent

2. Village: ☐

1. Mavdi 2. Pondhe

3. Caste : ☐

1. Brahmin 2. Gurav
3. Maratha 4. Mali
5. Nhavi 6. Sonar
7. Sutar 8. Dhangar
9. Ramoshi 10. Muslim
11. Neo-Buddhists.

4. Religion : ☐

1. Hindu 2. Muslim
3. Buddhist.

II. HOUSEHOLD INFORMATION

Note: All individuals who share a kitchen constitute a household.

1. Household Table:
(Start with the name of the head of the household.)

1. No.	2. Name	3. Relation-ship	4. Age	5. Sex	6. Com-pleted school-ing	7. Mari-tal sta-tus	8. Occu-pa-tion

CODES

Column No.3

Relationship with head of household

1. Self
2. Spouse
3. Son/daughter
4. Mother/Father
5. Brother/Sister
6. Son-in-law/ daughter-in-law
7. Brother-in-law/ sister-in-law
8. Grandchild
9. Nephew/Niece
10. Father-in-law/ Mother-in-law
11. Any other (specify)

Column No.4

Age

1. Below 1 year
2. 1 - 4 years
3. 5-14 years
4. 15-24 years
5. 25-34 years
6. 35-44 years
7. 45-54 years
8. 55 years & above.

Column No.5

Sex

1. Male 2. Female

Column No.6

Completed Schooling

1. Illiterate 2. Literate only 3. 1st to 4th Std.
4. 5th - 7th Std. 5. 8th Std.-10th/ 11th Std. 6. 12th Std./Inter
7. Graduate 8. Technical Diploma 9. Professional degree.

Column No.7

Marital Status

1. Never Married 2. Currently Married 3. Deserted
4. Separated 5. Divorced 6. Widowed

Column No. 8

Occupation

1. Non-Worker
2. Student
3. Housewife
4. Paid domestic work
5. Peasant
6. Agricultural labour
7. Peasant + Agricultural labour
8. E.G.S. Worker
9. Peasant + E.G.S. Worker
10. Agricultural + Non-agricultural labour
11. Artisan (Specify)
12. Self-employed (Specify)
13. Service (Specify)
14. Professional (Specify)
15. Any other (Specify)

2. Land Ownership : (in Hectares - Ares)

Irrigated	Rainfed	Uncultivable	Total

3. House Ownership : ☐

1. Owned
2. Rented
3. Any other (specify)

4. Housing details :

Floor ☐ Walls ☐ Roof ☐

1. Kuccha
2. Pucca.

5. Other facilities at home (in the house) ;

a) Electricity ☐

b) Sanitation ☐

c) Gobar Gas ☐

d) Latrine ☐

1. Yes
2. No.

III. FINANCIAL DETAILS

1. Annual Produce From Land
(Specify whether Kgs., Quintals or sackful)

1	2	3	4	5	6	7	8	9
Wheat	Jowar	Bajra	Rice	Fodder	Vege-table (Spe-cify)	Onion	Fruit (Spe-cify)	Any other (Spe-cify)

2. Monthly Income

1	2	3	4	5	6	7
No.	Name of the wage earner	Type of Work	No.of days employed annually	Daily cash	Wage in kind	Corrected monthly wages

3. Any other source of income :

Specify: Rs. _____ x - N.A.

4. Total amounts of debt :

Specify : Rs. -------- x - N.A.

5. Does the household have :

a) Bank account :

1. Yes
2. No

b) Postal account:

c) Any other account:
(Specify)

IV. FERTILITY AND MATERNITY

Note: For all ever married women.

1. Record of Fertility:

No.	Name	Total No. of con-cep-tions	Total No. of abor-tions	Total no. of still-births			Live births			Current-ly living child-ren			Child-ren dead			Present-ly pregnant Yes/No	Current-method of family planning	Any problem due to contra-ception
				M	F	T	M	F	T	M	F	T	M	F	T			

2. Record of death of children:

1. No.	2. Name	3. Mother's name	4. Sex	5. Age at death	6. Reason

3. Record of Abortion:

1. No.	2. Name	3. Miscarriage/MTP	4. Month of pregnancy	5. Reason	6 Performed by	7 Cost	8. Health Problems

4. Ante-natal care (ANC) & Delivery Practice:

Note:- Record first & most recent delivery.

1 No.	2 Name	3 Age at delivery	4 A.N.C. Services	5 Place of delivery	6 Delivery conducted by	7 Outcome of delivery	8 Cost	9 Post-partum problems

5. Infant Feeding Practices :

1	2	3	4	5	6	7	8	9	10	11	12
No.	Name	Sex	Breast feeding commenced	Whether bottle-fed	Whether substitute milk used (Specify)	Breast feeding withdrawn	Supplementary food introduced	Details of supplementary and weaning foods	Solids introduced	Details of solid foods	Any special inputs? (Specify)

6. Post-Natal Care (PNC) :

1	2	3	4	5	6				7
No.	Name	Total Rest	Return to domestic work	Return to outdoor work	Immunisation				Given by
					Smallpox	B.C.G.	D.P.T.	Measles	

IV. ACCESS TO HEALTH CARE:

1) Knowledge:

a) Where is the nearest P.H.C.?

b) Do you ever go to the P.H.C.?

c) How many times during the last three months have you visited the P.H.C.?

d) Do you know Mr. (M.P.W.)?

e) What does he do?

f) During the last three months, have you utilised his services? If yes, specify.

g) Do y8u know Ms. (A.N.M.)?

h) What does she do?

i) During the last three months, have you utilised her services? If yes, specify.

j) Do you know, Mr/Ms. (C.H.V.)?

k) What does he/she do?

l) During the last three months, have you utilised her/her services? If yes, specify.

2) Utilisation:

a) Where do you go when you fall ill.

Illness	Male	Female	Child
Minor illnesses			
Major illnesses			
Gynaecological complaints			

b) Morbidity Table

Note: Record all illness episodes for all the household members during the last one month.

1	2	3	4	5	6
No.	Name	Illness	Referred to	Treatment Given	Cost

VI. WOMEN'S WORK

1. Unpaid domestic labour.

a) Amount of time spent daily on:

i) Cooking ii) Cleaning iii) Water Fetching

iv) Firewood fetching v) Other chores (specify)

2. Outdoor labour

a) Kinds of labour engaged in (specify)

b) Daily amount of time spent on the labour.

3. Work Description & Occupational Health.

1	2	3	4	4
No.	Name	Work description (for all seasons)	Posture	Health Hazards

4. Does your indoor and outdoor work affect your health in any way? Specify.

   If so, have you reported your problems to anybody?

   What did he/she do about it?

5. What facilities are available at your workplace?

6. Does the double burden of family and social labour not cause stress? If so, how do you cope?

7. How do you feel about women earning a wage?

8. Would you like your daughter or daughter-in-law to earn a wage outside home? If so, what kind of jobs do you think they should do?

LIST OF PUBLICATIONS ON WOMEN & HEALTH AVAILABLE AT FRCH LIBRARY

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55) Women in Poverty : The Energy, Health and Nutrition Syndrome, Batliwala Srilatha (Ms.), February 1983.

63) Women and Health : A Critical Review of Available Information in India. Daswani Mona (Ms.)/Britto Gabriel A.A. (Mr.), March 1984.

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72) Reproductive Technology, Gupte Manisha (Ms.), Eve's Weekly, November 9-15, 1985, pp. 32-33.

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89) Sex Determination Tests and Female Foeticide in the city of Bombay, Kulkarni Sanjeev (Dr.), March 1987.

97) Why we must ban EP drugs, Duggal Ravi, Indian Post, August 6, 1987.

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